Faxed prescriptions will only be accepted from an authorized prescriber. Prescribers are reminded patients may choose any pharmacy of their choice.

Sage Specialty Pharmacy Behavioral Health Referral Form

WWW.SAGE-SPECIALTYPHARMACY.COM

Patient Information: Please provide a copy of the patient's insurance card or information

Patient Name:	DOB:	Gender:	Ht:	Wt:
Address:	City:	State:	Zip Code:	Phone:
Insurance:	Subscriber's Name:		ID#:	Group#:

Allergies: □NKDA □ List Allergies:

Clinical Information: please provide recent clinical notes, labs, and tests to expedite the prior authorization process

ICD-10 and Diagnosis: ______________________________________
Patient has history of nonadherence with oral meds: □ Yes □ No
Past Medical History: ______________________________________

Previously Failed Medications (dose and duration): _____________
____
____

Prescription Information

Medication	Strength	Sig	Quantity	Refills
□ Abilify Maintena	□ 300mg PFS □ 400mg PFS	□ Inject 1 syringe IM every 4 weeks	1 Box	
□ Aristada Initio	□ 675mg PFS	□ Inject 1 syringe IM along with maintenance Aristada dose □ Aripiprazole 30mg: take 1 tablet by mouth once with Aristada Initio injection	□ 1 Box □ 1 Tab	0
□ Aristada	□ 441mg PFS □ 662mg PFS □ 882mg PFS □ 1064mg PFS	□ Inject 1 syringe IM every 4 weeks □ Inject 1 syringe IM every 6 weeks □ Inject 1 syringe IM every 8 weeks □ Other:	1 Box	
□ Invega Sustenna	□ 39mg PFS □ 78 mg PFS □ 117mg PFS □ 156mg PFS □ 234mg PFS	□ Initial: Inject 234mg into the deltoid on day 1, then 156mg into the deltoid on day 8 □ Maintenance: Inject 1 syringe IM every 4 weeks	1 Box each 1 Box	0 ____
□ Invega Trinza	□ 273mg PFS □ 410mg PFS □ 546mg PFS □ 819mg PFS	□ Inject 1 syringe IM every 12 weeks	1 Box	
□ Perseris	□ 90mg Syringe □ 120mg Syringe	□ Inject 1 syringe SC every 4 weeks	1 Box	
□ Risperdal Consta	□ 12.5mg Vial □ 25mg Vial □ 37.5mg Vial □ 50mg Vial	□ Inject 1 vial IM every 2 weeks	1 Box	
□	□	□		

Prescriber Information

Name:	Phone:	Office Contact Name:	
Address:	City:	State:	Zip:
NPI:	DEA:	Fax and/or Email:	
Prescriber Signature:		Date:	□ DO NOT SUBSTITUTE

Sage Specialty Pharmacy – Phone: 414-861-7243 Fax: 414-906-0187 Address: 4001 N Oakland Ave Shorewood, WI 53211

I authorize Sage Specialty Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee and contains confidential information that may be protected health information under federal and state laws. If you are not the intended recipient, do not disseminate, distribute, or copy this fax. Please notify the sender immediately if you have received this document in error and then destroy this document immediately.