BHSI EAGAN
3460 WASHINGTON DR
STE#200
EAGAN, MN 55122
(PHONE) 651-769-6200
(FAX) 651-769-6249

BHSI Shakopee
327 S. MARSCHALL RD
STE#250
SHAKOPEE, MN 55379
(PHONE) 651-769-6500
(FAX) 651-769-6549

BHSI GOLDEN VALLEY
8441 WAYZATA BLVD
STE#140
GOLDEN VALLEY, MN 55426
(PHONE) 651-769-6300
(FAX) 651-769-6349

SPECIALTY INJECTION ORDER FORM

(FORM IS TO BE COMPLETED BY PRESCRIBING PHYSICIAN)

PATIENT INFORMATION

Name:_____DOB:_____Sex: M____F____
Address:_____City:_____State:_____Zip:_____
Home Phone:_____Cell:_____Work:_____
Emergency Contact Name:_____Phone:_____
Allergies:_____Wt:_____HT:_____Diabetic: Y or N
Patient Previously on Treatment?: Y or N Date of Last Injection:_____Received at:_____
Response:_____

PRESCRIBER INFORMATION

Name:_____MD/DO/NP/PA
Clinic Name:_____Address:_____
City:_____State:_____Zip:_____
Office Contact:_____Phone:_____Fax:_____
NPI:_____DEA:_____License:_____

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis:_____ ICD-10 Code:_____Date of Diagnosis:_____
Secondary Diagnosis:_____ _ICD-10Code:_____ Date of Diagnosis:_____
Is this the patient's first injection? Y or N Length of time on therapy:_____
Response:_____

PLEASE CHOOSE FROM ONE OF THE FOLLOWING MEDICATIONS:

☐ ABILFY MAINTENNA ☐300mg ☐400mg
Aripiprizole for extended-release injection suspension
If this is the first injection, length of time on oral med:_____
Date of Last injection:_____
Does patient have hypersensitivity to Aripiprazole?
(circle one) Yes or No
Frequency of Injection:_____
Special instructions:_____
_____

☐ INVEGA SUSTENNA ☐39mg ☐ 78mg ☐117mg
Paliperidone Palmitate Injection ☐156mg ☐ 234mg
If this is the first injection, length of time on oral med:_____
Date of last injection:_____
Does patient have hypersensitivity to Paliperidone, Risperidone?
(circle one) Yes or No
Frequency of Injection:_____
Specialinstructions:_____
_____

☐ ARISTADA ☐ 441 mg ☐662 mg ☐882 mg
Aripiprazole Lauroxil extended-release injectable suspension
If this is the first injection, length of time on oral med:_____
Last injection:_____ _____
Does patient have hypersensitivity to Aripiprazole?
(circle one) Yes or No
Frequency of Injection:_____
Specialinstructions:_____
_____

☐ INVEGA TRINZA ☐ 273mg ☐410mg ☐ 546m ☐819mg
3 month Paliperodme Palmitate injection
If this is the first injection, length of time on oral med:_____
Last injection:_____
Does patient have hypersensitivity to Paliperidone, Risperidone?
(circle one)Yes or No
Frequency of Injection:_____
Special instructions:_____
_____

☐ VIVITROL ☐ 380mg
Naltrexone extended-release injectable suspension
If this is the first injection, length of time on oral med_____
Last injection:_____ _____
Does patient have hypersensitivity to Naltrexone?
(circle one) Yes or No
Frequency of Injection:_____
Special instructions_____
_____

☐ RISPERDAL CONSTA ☐ 12.5mg ☐ 25mg ☐ 37.5mg ☐ 50mg
Riperidone long-acting imjection
If this is the first injection, length of time on oral med:_____
Last injection:_____ _____
Does patient have hypersensitivity to Paliperidone, Risperidone
(circle one) Yes or No
Frequency of Injection:_____
Special instructions:_____
_____

☐ OTHER:_____DOSE:_____
(Please attach separate order if needed) MAY REQUIRE 2 WEEK PRIOR NOTICE
If this is the first injection, length of time on oral med:_____
Last injection:_____ _____ Does patient have hypersensitivity to this medication?
(circle one)Yes or No
Frequency of Injection:_____
Special instructions:_____
_____
_____

RECOMMENDED PHARMACIES

BHSI recommends using the following specialty pharmacies to obtain injectable medications:

Genoa Pharmacy
317 York Ave. S.
St. Paul, MN 55130
Phone: 651-771-0286
Fax: 612-808-5181

Fairview Specialty Pharmacy
711 Kasota Ave. SE
Minneapolis, MN 55414
Phone: 612-672-5260
Fax: 1-866-347-4939

Geritom Pharmacy
10501 Florida Ave. S.
Bloomington, MN 55438
Phone: 952-854-1190
Fax: 952-854-1082

CVS Caremark Specialty Pharmacy
1-800-238-7828

IF YOU HAVE CHOSEN TO USE ONE OF THE ABOVE LISTED PHARMACIES, PLEASE CIRCLE YOUR CHOICE. IF YOU HAVE CHOSEN TO USE ANOTHER PHARMACY, PLEASE FILL IN THE INORMATION BELOW:

Pharmcay Name:_____
Address:_____
Phone :_____
Fax:_____

PLEASE INCLUDE ANY NECESSARY RELEASE OF INFORMATION FORMS IF INFORMATION IS TO BE EXCHANGED WITH BHSI

By signing this form and utilizing services at BHSI, you are authorizing BHSI and it's employees to serve as the designated agent to communicate with the above named patient's medical or prescription insurance company regarding any prior authorizations that may be necessary to obtain for coverage/administration of this medication.

_____ _____ (Circle one): Yes or No (Circle one): Yes or No
Physician Signature Date May substitute Dispense as written

INTERAL USE ONLY
BHSI AUTHORIZED SIGNATURE:_____ DATE:_____
REVIEWED BY:_____
MD/DO/NP/PA