sage elevate

Haloperidol Decanoate Orders

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www.sage-elevate.com/SubmitOrder

PATIENT INFORMATION

Patient Name: _____ **DOB**: _____ **Gender:** ☐ M ☐ F

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone: _____ **Email:** _____ **Ht:** _____ **Wt:** _____

Please Attach: ☐ Insurance cards ☐ History & Physical ☐ Most recent labs ☐ Medication list

☐ **NKDA** ☐ **Allergies:** _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____

Practice Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

REQUIRED INFORMATION

Documentation:

☐ Recent clinical and/or office visit notes supporting primary diagnosis

☐ Tried and failed prescribed medications *(please list)* _____

Has the patient been previously stabilized on anti psychotic medication before considering to HALOPERIDOL DECANOATE? ☐YES ☐ NO

HALOPERIDOL DECANOATE PRESCRIPTION

ICD-10 Diagnosis Codes:

☐ **F20.0** Paranoid Schizophrenia

☐ **F25.0** Schizo affective disorder, bipolar type

☐ **Other:** _____

☐ **New to Therapy** ☐ **Continuation of Therapy:** Date of last dose (if applicable): _____

Dosing/Frequency:

☑ **Haloperidol Decanoate should be administered by deep intramuscular injection.**

Every 4 weeks : ☐ 50 mg ☐ 100 mg

☐ **Refills:** _____

Sage Elevate Standing Orders:

☑ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name	Provider Signature	Date