

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 oral medications (*please list*) _____

Has the patient's tolerability to oral olanzapine been established prior to initiating ZYPREXA RELPREVV? ☐ YES ☐ NO

ZYPREXA RELPREVV PRESCRIPTION

ICD-10 Diagnosis Codes:

- ☐ **F20.0** Paranoid Schizophrenia
- ☐ **F25.0** Schizoaffective disorder, bipolar type
- ☐ **Other:** _____

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

Dosing/Frequency:

☒ **Zyprexa Relprevv administer deep intramuscular gluteal injection only**

During the first 8 weeks : ☐ 210 mg/2 weeks ☐ 405 mg/4 weeks ☐ 300 mg/2 weeks

After 8 weeks : ☐ 150 mg/2 weeks ☐ 300 mg/4 weeks ☐ 210 mg/2 weeks ☐ 405mg/4weeks ☐ 300 mg/2 weeks

☐ **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