EmblemHealth®

Medicaid Behavioral Health Injectable Form

Today's Date: ______/______/______

PLEASE PRINT

Member Name (First, Last)		
Member Identification Number		
Member Phone Number		
Address (no P.O. Box)		
City	State	ZIP
Provider Name		
M.D. NPI Number		
M.D. Signature (signature required, no stamps please)		
Facility/Provider's Office Name		
Phone Number	Fax Number	
Address (no P.O. Box)		
City	State	ZIP
Contact Person	Phone Number	

Patient DOB ______/______/______	Patient weight ________ kg	Patient height ________ in.
ICD-10	**Diagnosis** (in words)	

Please check one:

- ☐ Medical Benefit (delivered by Magellan to provider's office)
- ☐ Pharmacy Benefit (picked up by patient at a specialty network pharmacy)

Medical Benefit

Fill out below if requesting under Medical benefit only.

Note: Haldol Decanoate and Fluphenazine Decanoate do NOT require prior authorization.

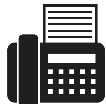
Injectable	Dose and Frequency
Abilify Maintena	
Aristada	
Invega Sustenna	
Invega Trinza	
Risperdal Consta	
Zyprexa Relprevv	
Vivitrol	

Pharmacy Benefit

Fill out below if requesting under Pharmacy benefit only.

Note: Haldol Decanoate and Fluphenazine Decanoate do NOT require prior authorization.

Injectable (Formulary alternatives)	Dose and Frequency
Abilify Maintena	
Risperdal Consta	
Vivitrol	
Other	



Please fax completed form to EmblemHealth Specialty Program at **1-877-243-4812**. Please call **1-888-447-0295** with any questions.

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