



Antipsychotic and Substance Abuse Referral Form
 Ph: (214) 919-2090 or (877) 753-6878
 Fax: 1 (888) 294-9434

Injection Training: MD Office
 Pharmacy to Arrange

Ship To: Patient Home MD Office

MAIN POINT OF CONTACT
 Name: _____
 Phone: _____

PATIENT INFORMATION (Use this area or attach patient demographics)
 Name: _____ Phone: _____ Phone 2: _____
 Home Address: _____ City: _____ State: _____ Zip Code: _____
 DOB: _____ SSN: _____ Sex: Male Female Height: _____ Weight: _____ lbs.
 Emergency Contact: _____ Phone: _____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))
 Primary Insurance: _____ Secondary Insurance: _____
 ID#: _____ RxBin: _____ ID#: _____ RxBin: _____
 RxGroup: _____ Pcn: _____ RxGroup: _____ Pcn: _____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)
 Primary Diagnosis: _____ ICD10 Code: _____
 Secondary Diagnosis: _____ ICD10 Code: _____
 Previous Treatment: _____ AST: _____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Strength	Directions	QTY	Refill
<input type="checkbox"/> Abilify Maintena*	<input type="checkbox"/> 300 mg syringe <input type="checkbox"/> 400 mg syringe	Inject IM once monthly *Dose adjust based on concomitant therapy		
<input type="checkbox"/> Evzio	<input type="checkbox"/> 0.4 mg/0.4 mL (Auto-injector)	Administrator to outer portion of thigh at onset of crisis then call 911 immediately. May repeat with new injector in 2-3 minutes if needed	<input type="checkbox"/> 1 carton = 2 - 0.4 mg/0.4 mL auto-injectors and 1 trainer. <input type="checkbox"/> 2 cartons = 4 - 0.4 mg/0.4 mL auto-injectors and 2 trainers.	
<input type="checkbox"/> Invega Sustenna Syringe	Starter Dose: <input type="checkbox"/> 156 mg/mL <input type="checkbox"/> 234 mg/mL Maintenance: <input type="checkbox"/> 39 mg/0.25 mL <input type="checkbox"/> 78 mg/0.5 mL <input type="checkbox"/> 117 mg/0.75 mL <input type="checkbox"/> 156 mg/mL <input type="checkbox"/> 234 mg/mL	Initial Dosage: <input type="checkbox"/> Inject 234 IM on treatment day 1, then 156 mg IM 1 week later Maintenance: <input type="checkbox"/> Inject IM every month		
<input type="checkbox"/> Latuda	<input type="checkbox"/> 20 mg <input type="checkbox"/> 40 mg <input type="checkbox"/> 60 mg <input type="checkbox"/> 80 mg <input type="checkbox"/> 120 mg	Take by mouth once daily		
<input type="checkbox"/> Naltrexone	<input type="checkbox"/> 50 mg (Oral Tablets)	Take 1 tablet by mouth once daily		
<input type="checkbox"/> Pristiq	<input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> 100 mg	Take by mouth once daily		
<input type="checkbox"/> Risperdal Consta	<input type="checkbox"/> 12.5 mg kit <input type="checkbox"/> 25 mg kit <input type="checkbox"/> 37.5 mg kit <input type="checkbox"/> 50 mg kit	Inject IM every 2 weeks		
<input type="checkbox"/> Vivitrol	<input type="checkbox"/> 380mg (Extended-release Injectable Suspension)	Inject 380 mg into a gluteal muscle by doctor's office staff once every 28 days		
<input type="checkbox"/> Zyprexa Relprevv Kit	Starter Dose: <input type="checkbox"/> 210 mg kit <input type="checkbox"/> 300 mg kit <input type="checkbox"/> 405 mg kit Maintenance: <input type="checkbox"/> 210 mg kit <input type="checkbox"/> 300 mg kit <input type="checkbox"/> 405 mg kit	Initial Dosage: <input type="checkbox"/> Inject IM every ___ weeks for ___ dose(s) Maintenance: <input type="checkbox"/> Inject IM every ___ weeks		



Allergies:

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name: _____ NPI#: _____
 Address: _____ City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____

***Prescriber Signature:** _____ **Date:** _____

Confidentiality Statement: This message is intended only for the individual or entity to which it is addressed. It may contain information which may be proprietary and confidential. It may also contain privileged, confidential information which is exempt from disclosure under applicable laws, including the Health Insurance Portability and Accountability Act (HIPAA). If you are not the intended recipient, please note that you are strictly prohibited from disseminating or distributing this information (other than to the intended recipient) or copying this information. If you received this communication in error, please notify the sender immediately at the address and telephone number set forth herein and obtain instructions as to proper destruction of the transmitted material. Thank you.

Please fax completed form to 1 (888) 294-9434