InfuCare Rx

Atypical Antipsychotic Referral Form

of Pages Faxed: _____
Fax Referral To: 844-504-3278
Phone: 877-327-8881

Date Required: _____ Ship To: ☐ Patient ☐ MD Office ☐ Other: _____

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ ☐ Male ☐ Female
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ F99 Unspecified Mental Disorder
☐ Other: _____

For Invega only:
Day 1 dose _____ Date: _____
Day 8 dose _____ Date: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in %BSA: _____
Allergies: _____ ☐ NKDA
Injection Training/Home Health RN visit is necessary. ☐ Yes ☐ No
Site of Care: ☐ Home ☐ MD Office ☐ Other: _____
☐ New to Therapy Date of Last Administration: _____

PRESCRIPTION INFORMATION

Medication:	Dose/Strength:	Directions:	Quantity:	Refills:
☐ Abilify Maintena®	☐ Kit ☐ Syringe	☐ Administer 160mg IM every month ☐ Administer 200mg IM every month ☐ Administer 300mg IM every month ☐ Administer 400mg IM every month	☐ 1 unit ☐ 3 units	
☐ Aristrada Initio ® (aripiprazole lauroxil)	☐ WITH oral aripiprazole	☐ Administer 160mg IM every month ☐ Administer 200mg IM every month	☐ 1 unit ☐ 1 tablet	
☐ Aristrada® (aripiprazole lauroxil)		☐ Administer 441mg IM every month ☐ Administer 662mg IM every month ☐ Administer 882mg IM every 6 weeks ☐ Administer 1064mg IM every 2 months	☐ 1 unit ☐ 3 units	
☐ Invega Sustenna® (paliperidone)		☐ **Loading Dose (Day 1):** Administer 234mg IM (deltoid) on treatment day 1 ☐ **Follow Up Dose (Day 8):** Administer 156mg IM (deltoid) on treatment day 8 ☐ **Maintenance Dose (Day 8):** ☐ Administer 39mg/0.25mL IM (deltoid/VG) every 4 weeks ☐ Administer 78mg/0.5mL IM (deltoid/VG) every 4 weeks ☐ Administer 117mg/0.75mL IM (deltoid/VG) every 4 weeks ☐ Administer 156mg/1mL IM (deltoid/VG) every 4 weeks ☐ Administer 234mg/1.5mL IM (deltoid/VG) every 4 weeks	☐ 1 unit ☐ 3 units	
☐ Invega Trinza® (paliperidone)		☐ Administer 12.5mg IM every 2 weeks ☐ Administer 25mg IM every 2 weeks ☐ Administer 37.5mg IM every 2 weeks ☐ Administer 50mg IM every 2 weeks	☐ 1 unit ☐ 3 units	
☐ Resperdal Consta® (risperidone)		☐ Administer 12.5mg IM every 2 weeks ☐ Administer 25mg IM every 2 weeks ☐ Administer 37.5mg IM every 2 weeks ☐ Administer 50mg IM every 2 weeks	☐ 1 unit ☐ 3 units	
☐ Other:				

ADDITIONAL COMMENTS

Prescriber Signature: _____ **Date:** _____