

Abilify Maintena Referral Form Phone 877.421.3405 Fax 877.421.3406

hone 877.421.3405 Fax 877.421.3406 546 West Las Tunas Drive, San Gabriel, CA 91776

r	n.	m	Λ	~	1	_	

Patient Information												
Name (last, first)				one I Home I Cell	Date of Birth							
Home Address, City, State	ZIP											
Shipping Address, City, State (if different from ab	ZIP											
Social Security Number	Male Allergies Female					1						
Healthcare Provider Information												
Prescriber's First and Last Name												
Address, City, State						ZIP						
Nurse/Key Contact P	urse/Key Contact Physician NPI		DEA		License							
Insurance Information (attach cop	pies of card and fax along w	rith this forr	m)									
Primary Insurance				e, 🖵 Dependent)	ID Number	RXGRP						
Secondary Insurance	Phone	N	Name (Insured 🗖 Self, 🗖 Spous	e, 🖵 Dependent)	ID Number	RXGRP						
Pharmacy Benefit Card	RXBIN	N	Member/Subscriber ID Number		RXGRP	PCN						
Additional Information Today's Date Start Date Deliver to: Nurse Training Needed? Special Instructions												
□ Home □ Physician □ Yes □ No												
Diagnosis (Please check the follo	owing)											
295 Schizophrenic Disorders 205 0 Simple Type Schizephren			ICD 9 Code:									
 295.0 Simple Type Schizophrer 295.1 Disorganized Type of Sch 												
295.2 Catatonic Type Schizoph												
	□ 295.3 Paranoid Type Schizophrenia											
295.4 Schizophreniform Disord	ler											
295.5 Latent Schizophrenia												
295.6 Residual Type 295.7 Schize Affective Disorder	~											
 295.7 Schizo-Affective Disorde 295.8 Other Specified Types of 												
295.9 Unspecified Schizophren	•											
Physician Orders (Please check to	he following											
Prescribed dose of ABILIFY MAINTEN		⊒400mg	Reason for D/		ad intolerable side effects							
Quantity: Refills: Directions:				Constipation	n idal Symptoms							
Directions				Cardiac Eve								
Prior Oral Medications: DGeodon	□Zyprexa □Seroqu	el 🗆 Al	bilify	 Cardiac Events Tried for 1 month and was ineffective 								
Reason for D/C: D Tried and had intolerable side effects Please attach any relevant progress notes												
Tried for 1 mont	h and was ineffective		Comments:									
Prior Injectable Medications: 🗆 Risperdal Consta 🗅 Invega Sustenna												
🗆 Haloperidol Decanoate 🗆 Flupehanize Decanoate												
		ala dha c	and the sector of the sector o									
When sending a referral please include Physician Signature:	e an cunical information, in	cluaing rec	cent lab values, relevant to	performing a prior a	authorization and copi Date							

Physician Signature: _____ Date _____ / _____ I authorize MedQuick Pharmacy and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so, to release clinical information via phone to the appropriate third party payer.

CONFIDENTIALITY NOTICE: The information contained in this transmittal belongs to Med Quick Prescription Shoppe and may include information that is confidential, privileged and protected from disclosure under applicable law. If you are not the intended recipient, you are hereby notified that any disclosure, copying or distribution of this information is strictly prohibited. If you have received this document in error, please immediately notify us by phone at 877-421-3405, and then destroy this document. Thank you.