MEDQUICK PHARMACY

Abilify Maintena Referral Form

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

Patient Information

Name (last, first)	Phone ❑ Home ❑ Cell	Date of Birth
Home Address, City, State		ZIP
Shipping Address, City, State (if different from above)		ZIP
Social Security Number	❑ Male ❑ Female	Allergies

Healthcare Provider Information

Prescriber's First and Last Name	Phone	Fax
Address, City, State		ZIP

Nurse/Key Contact	Physician NPI	DEA	License

Insurance Information *(attach copies of card and fax along with this form)*

Primary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Secondary Insurance	Phone	Name (Insured ❑ Self, ❑ Spouse, ❑ Dependent)	ID Number	RXGRP
Pharmacy Benefit Card	RXBIN	Member/Subscriber ID Number	RXGRP	PCN

Additional Information

Today's Date	Start Date	Deliver to: ❑ Home ❑ Physician	Nurse Training Needed? ❑ Yes ❑ No	Special Instructions

Diagnosis *(Please check the following)*

❑ 295 Schizophrenic Disorders
❑ 295.0 Simple Type Schizophrenia
❑ 295.1 Disorganized Type of Schizophrenia
❑ 295.2 Catatonic Type Schizophrenia
❑ 295.3 Paranoid Type Schizophrenia
❑ 295.4 Schizophreniform Disorder
❑ 295.5 Latent Schizophrenia
❑ 295.6 Residual Type
❑ 295.7 Schizo-Affective Disorder
❑ 295.8 Other Specified Types of Schizophrenia
❑ 295.9 Unspecified Schizophrenia

ICD 9 Code:_____

Physician Orders *(Please check the following)*

Prescribed dose of ABILIFY MAINTENA®(aripirazole): ❑ 300mg ❑ 400mg
Quantity:_____ Refills:_____
Directions:_____

Prior Oral Medications: ❑ Geodon ❑ Zyprexa ❑ Seroquel ❑ Abilify

Reason for D/C: ❑ Tried and had intolerable side effects
❑ Tried for 1 month and was ineffective

Prior Injectable Medications: ❑ Risperdal Consta ❑ Invega Sustenna
❑ Haloperidol Decanoate ❑ Flupehanize Decanoate

Reason for D/C: ❑ Tried and had intolerable side effects
❑ Constipation
❑ Extrapyramidal Symptoms
❑ Cardiac Events
❑ Tried for 1 month and was ineffective

Please attach any relevant progress notes
Comments:

When sending a referral please include all clinical information, including recent lab values, relevant to performing a prior authorization and copies of patient's insurance cards

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.