MENTAL HEALTH REFERRAL FORM A

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
☐ Abilify Maintena (aripiprazole) ☐ Kit ☐ Syringe	☐ Administer 160mg IM every month ☐ Administer 200mg IM every month ☐ Administer 300mg IM every month ☐ Administer 400mg IM every month	☐ 1 kit/syringe	
☐ Aristada (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 syringe	
☐ Aristada Initio (aripiprazole lauroxil) ☐ WITH oral aripiprazole 30mg	☐ Administer 675mg IM one time. ☐ Take 1 tablet (30mg) by mouth one time in conjunction with Aristada Initio and Aristada injections	☐ 1 syringe ☐ 1 tablet	

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy ☐ Pharmacist may administer

Date Medication Needed: _____

Phone: 877-466-8028 | Fax: 877-466-8040
www.albertsons.com/specialtycare
For Texas only: Phone: (512) 280-1201

E-Scribe Information:
MedCart Pharmacy • 32131 Industrial Rd. Livonia, MI 48150 • NCPDP 2374445 • NPI 1225343221
E-Scribe: 9911 Brodie Ln • Austin, TX 78748 • NPI: 1952330912 • NCPDP: 4525993

MENTAL HEALTH REFERRAL FORM B-I

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

Prescription Information

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
☐ 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 kit	
☐ Invega Trinza (paliperidone)	☐ Administer 273mg/0.875mL IM every 3 months ☐ Administer 410mg/1.315mL IM every 3 months ☐ Administer 546mg/1.75mL IM every 3 months ☐ Administer 819mg/2.625mL IM every 3 months	☐ 1 syringe	

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Date of Last Administration:

For Invega only:

Day 1 dose _____ mg Date: _____

Day 8 dose _____ mg Date: _____

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy ☐ Pharmacist may administer

Date Medication Needed: _____

Phone: 877-466-8028 | Fax: 877-466-8040

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MENTAL HEALTH REFERRAL FORM J-Z

Albertsons Companies Specialty Care | MedCart Specialty Pharmacy | Jewel Osco | Albertsons | Safeway | Vons | Acme | Shaw's | Star Market | Pavilions | Carrs | Randalls | Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

Comorbidities: (list here or attach a list): _____

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

MEDICATION	DIRECTIONS	QUANTITY	REFILLS
☐ Perseris (risperidone)	☐ Administer 90mg subcutaneously in the abdomen once a month. ☐ Administer 120mg subcutaneously in the abdomen once a month.	☐ 1 kit	
☐ Risperdal 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 dose pack	
☐ Other Medication Name:			

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy ☐ Pharmacist may administer

Date Medication Needed: _____

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