MENTAL HEALTH REFERRAL FORM A

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): ______________________

Prescription Information

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

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: ______________________

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Phone: 877-770-4633 | Fax: 877-771-4633
www.albertsons.com/specialtycare

E-Scribe Information:
Albertsons/Safeway Pharmacy • 12874 E. Florence Ave.
Santa Fe Springs, CA 90670 • NCPDP 5617418 • NPI 1164451100

For Texas only: Phone: 512-891-4360
E-Scribe: 6600 Mopac Expressway South • Austin, TX 78749 • NPI: 1154350122 • NCPDP: 4593869

MENTAL HEALTH REFERRAL FORM B-I

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 Date Medication Needed: ______________

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MENTAL HEALTH REFERRAL FORM J-Z

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
☐ 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 Date Medication Needed: ______________

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