MedicoRx Specialty & HOME INFUSION PHARMACY

Schizophrenia Injectable Medications

REFERRAL FORM

Phone: 818-390-9696 Toll-free: 855-265-7850 ● Fax: 818-804-3492 Toll-free fax: 855-450-6717 ● info@MedicoRX.com

Patient information		Prescriber information	
Name:	**DOB:**	**Prescriber's Name:**	
Address: **City, State, Zip**		**NPI#**	
		DEA#	**License#**
Phone #	**Alt#**	**Address** **City, State, Zip**	
SSN:			
Height:	**Wt:**	**Phone #**	**Fax #**
Allergies:			
Emergency Contact/ Phone #		**Contact Person:**	

Clinical Consideration

Diagnosis (ICD 10) : □ F20.0 Paranoid schizophrenia

□ F20.1 Disorganized schizophrenia

□ F20.2 Catatonic schizophrenia

□ F20.3 Undifferentiated schizophrenia

□ F20.5 Residual schizophrenia

□ F20.89 Other schizophrenia

□ F20.9 Schizophrenia, unspecified

Other (please specify)____

Medication	Dose/Strength	Directions for Use	Quantity	Refills
□ **Abilify Maintena®** (Aripeprazole)	□ **400 mg** □ **300 mg**	**Inject IM once every 4 weeks**		
□ **Invega Sustenna®** (Paliperidone)	□ **39 mg** □ **78 mg** □ **117 mg** □ **156 mg** □ **234 mg**	**Inject IM once every 4 weeks**		
□ **Risperidal Consta®** (Resperidone)	□ **12.5 mg** □ **25 mg** □ **37.5 mg** □ **50 mg**	**Inject IM once every 2 weeks**		
□ **Zyprexa Relprevv®** (Olanzapine)	□ **150 mg** □ **210 mg** □ **300 mg** □ **405 mg**			

By signing this form I authorize MedicoRX and its representatives to act as my agent in order to initiate and execute the insurance prior authorization process and, in doing so release clinical information via phone to the appropriate third party payer.

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Prescriber's signature (no stamps) if brand required check this □ DAW___ **Date**