MAIN POINT OF CONTACT
Name:_____
Phone:_____

ASP CARES

Antipsychotic and Substance Abuse Referral Form
Ph: (214) 919-2090 or (877) 753-6878
Fax: 1 (888) 294-9434

Injection Training: ☐ MD Office ☐ Pharmacy to Arrange
Ship To : ☐ Patient Home ☐ MD Office

PATIENT INFORMATION (Use this area or attach patient demographics)

Name:_____ Phone:_____ Phone 2:_____
Home Address:_____ City:_____ State:_____ Zip Code:_____
DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female Height:_____ Weight:_____lbs.
Emergency Contact:_____ Phone:_____

INSURANCE INFORMATION (Use this area or attach copy of insurance card(s))

Primary Insurance:_____ Secondary Insurance:_____
ID#:_____ RxBin:_____ ID#:_____ RxBin:_____
RxGroup:_____ Pcn:_____ RxGroup:_____ Pcn:_____

MEDICAL ASSESSMENT (Use this area or attach patient labs and other authorization information)

Primary Diagnosis:_____ ICD10 Code:_____
Secondary Diagnosis:_____ ICD10 Code:_____
Previous Treatment:_____ AST:_____

PRESCRIPTION INFORMATION *(Use this area or attach copy of RX(s))

Medication	Strength	Directions	QTY	Refill
☐ **Abilify Maintena***	☐ 300 mg syringe ☐ 400 mg syringe	Inject IM once monthly *Dose adjust based on concomitant therapy		
☐ **Evzio**	☐ 0.4 mg/0.4 mL (Auto-injector)	Administrator to outer portion of thigh at onset of crisis then call 911 immediately. May repeat with new injector in 2-3 minutes if needed	☐ 1 carton = 2 - 0.4 mg/0.4 mL auto-injectors and 1 trainer. ☐ 2 cartons = 4 - 0.4 mg/0.4 mL auto-injectors and 2 trainers.	
☐ **Invega Sustenna Syringe**	Starter Dose: ☐ 156 mg/mL ☐ 234 mg/mL Maintenance: ☐ 39 mg/0.25 mL ☐ 78 mg/0.5 mL ☐ 117 mg/0.75 mL ☐ 156 mg/mL ☐ 234 mg/mL	Initial Dosage: ☐ Inject 234 IM on treatment day 1, then 156 mg IM 1 week later Maintenance: ☐ Inject IM every month		
☐ **Latuda**	☐ 20 mg ☐ 40 mg ☐ 60 mg ☐ 80 mg ☐ 120 mg	Take by mouth once daily		
☐ **Naltrexone**	☐ 50 mg (Oral Tablets)	Take 1 tablet by mouth once daily		
☐ **Pristiq**	☐ 25 mg ☐ 50 mg ☐ 100 mg	Take by mouth once daily		
☐ **Risperdal Consta**	☐ 12.5 mg kit ☐ 25 mg kit ☐ 37.5 mg kit ☐ 50 mg kit	Inject IM every 2 weeks		
☐ **Vivitrol**	☐ 380mg (Extended-release Injectable Suspension)	Inject 380 mg into a gluteal muscle by doctor's office staff once every 28 days		
☐ **Zyprexa Relprevv Kit**	Starter Dose: ☐ 210 mg kit ☐ 300 mg kit ☐ 405 mg kit Maintenance: ☐ 210 mg kit ☐ 300 mg kit ☐ 405 mg kit	Initial Dosage: ☐ Inject IM every ___ weeks for ___ dose(s) Maintenance: ☐ Inject IM every ___ weeks		

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Allergies:

ALL controlled substance quantities must be hand written in number and letter form

Prescriber Name:_____ NPI#:_____
Address:_____ City:_____ State:____ Zip Code:_____
Phone:_____ Fax:_____

***Prescriber Signature:_____ Date:_____**

Please fax completed form to 1 (888) 294-9434