ivira specialty pharmacy

Mental Health Referral Form

Please fax completed referral form to ivira:
(302) 499-8729
Please contact office for questions:
(302) 499-8727

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PREFERRED CONTACT #:
DATE OF REFERRAL:	SECONDARY CONTACT #:
SOCIAL SECURITY NUMBER:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:

PRIMARY DIAGNOSIS: PLEASE PROVIDE ICD-IO CODE

☐ F20.9 - Schizophrenia, unspecified ☐ F33 - Major Depressive Disorder ☐ F31 - Bipolar Affective Disorder
☐ OTHER: _____ - _____

PRIOR THERAPY: PLEASE PROVIDE MEDICATION HISTORY

PRIOR THERAPY (if any):	APPROX START DATE:	APPROX. END DATE:	REASON FOR DISCONTINUATION:

PATIENT INFORMATION:

ALLERGIES: ☐ NKDA

HEIGHT: ____ Ft ____ In WEIGHT: ____ Lb or ____ Kg

GENDER: ☐ F ☐ M

I hereby authorize Ivira to contact my prescribing provider to coordinate the delivery, receipt and storage of my prescription medication for the sole purpose of administration by my prescribing provider at my next scheduled appointment. Signature serves as the Patient Ship Authorization.

PATIENT SIGNATURE:

REQUIRED DOCUMENTATION: PLEASE PROVIDE A COPY OF THE FOLLOWING DOCUMENTS

☐ 1. INSURANCE CARD (Front & Back) ☐ 2. MOST RECENT LABS ☐ 3. PATIENT DEMOGRAPHICS ☐ 4. H & P

MEDICATION SELECTION:

Abilify Maintena 400MG U.S. FULL PRESCRIBING INFORMATION	☐ PREFILLED DCS 400 MG ☐ PREFILLED DCS 300 MG ☐ VIAL KIT 400 MG ☐ VIAL KIT 300 MG	☐ INJECT IM EVERY 4 WEEKS ☐ INJECT _____ MG IM EVERY ____ WEEKS	QTY: 1 SYRINGE REFILLS:_____
REXULTI brexpiprazole tablets U.S. FULL PRESCRIBING INFORMATION	☐ _____ MG BY MOUTH DAILY		QTY: _____TABS REFILLS:_____

PRESCRIBER INFORMATION:

PHYSICIAN NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	LICENSE #:
CITY, STATE, ZIP:	NPI:

PHYSICIAN SIGNATURE: DATE: