TROPICANA PHARMACY

LAI Referral Form

Phone: (408)251.6441 Fax: (408) 729.6181
1167 South King Road, San Jose, CA 95122

Patient Information

Last Name	First Name		Home Phone	Work/Mobile Phone	
Home Address			City	State	ZIP
Shipping Address (if different from above)			City	State	ZIP
Social Security Number	Gender (M/F)	Weight	Date of Birth	Allergies	
Emergency Contact	Phone		Primary Caregiver	Phone	

Healthcare Provider Information: **Indicates Required Field*

Practice/Facility Name	**Physician First and Last Name***		**Phone***	Fax
Address*		**City***	**State***	**ZIP***
Physician NPI#*	Physician UPIN#	Physician DEA#	Physician State License #	
Nurse/Key Contact		Phone or Pager Number	Email	

Medication	Dose/Strength	Sig	Qty.	Refills
☐Haloperidol Decanoate	☐50mg/ml ☐100mg/ml	☐Administer _____ IM Q4W	____	____
☐Fluphenazine Decanoate	☐25mg/ml	☐Administer _____ IM Q4W	____	____
☐Risperdal Consta	☐12.5mg/2ml ☐25mg/2ml ☐37.5mg/2ml ☐50mg/2ml	☐Administer _____ IM Q2W	____	____
☐Abilify Maintena	☐300mg/vial ☐400mg/vial ☐300mg Prefilled Syringe ☐400mg Prefilled Syringe	☐Administer _____ IM Q4W	____	____
☐Invega Sustenna	☐39/0.25ml ☐78mg/0.5ml ☐117/0.75ml ☐156/1ml ☐234mg/1.5ml	☐Initiation – Administer 234mg IM on Day 1 ☐Initiation – Administer 156mg IM on Day 8 ☐Routine - Administer _____ IM Q4W	1 1 ____	 ____
☐Invega Trinza	☐273mg/0.875ml ☐410mg/1.315ml ☐546mg/1.75ml ☐819mg/2.625ml	☐Administer _____ IM Q12W	____	____
☐Aristada	☐441mg/1.6ml ☐662mg/2.4ml ☐882mg/3/2ml	☐Administer 441mg IM Q4W ☐Administer 662mg IM Q4W ☐Administer 882mg IM Q4W	____	____

Physician Signature:_____ ❑ **DAW (Dispense as Written) Date** ____/____/____

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