Coordination of Care Form

To connect with a Patient Experience Liaison (PEL) for personalized and local support, please contact Otsuka Connect by using the information found at the bottom of this page.

Please fill out this form as completely as possible to ensure optimal coordination of care and help the patient take their medication as prescribed. When finished, fax the completed form to the selected outpatient care site.

TO

Next Site of Care Information

Site Name: ______________________

Address: ______________________

Contact Name: ______________________

Contact Phone: (_____) _____ - _______

Fax: (_____) _____ - _______

Date of Appointment: ____ /____ /_______

FROM

Referring/Current Site Information

Site Name: ______________________

Address: ______________________

Contact Name: ______________________

Contact Phone: (_____) _____ - _______

Prescriber Name: ______________________

Date of Discharge: ____ /____ /_______

PHARMACY

Pharmacy Where Prescription Was Sent

Pharmacy Name: ______________________

Address: ______________________

Phone: (_____) _____ - _______

BILLING

Please complete the following and/or provide a photocopy of front and back of insurance, prescription, and, if applicable, copay assistance card(s).

Primary Insurance: ______________________

ID #: _______ RXBIN #: _______ RXPCN #: _______

Group #: _______________ Plan #: _________

Secondary Insurance: ______________________

ID #: _______ RXBIN #: _______ RXPCN #: _______

Group #: _______________ Plan #: _________

Medicaid #: ______________________

Medicare Part A Effective Date: ____ /____ /_______

Medicare Part B Effective Date: ____ /____ /_______

PATIENT

Patient Name: ______________________

Date of Birth: ____ /____ /_______ Sex: M F

Phone: (____) ____ - ______ Cell: (____) ____ - ______

Address: ______________________

City: ______________ State: _____ Zip: _______

Care Partner Name: ______________________

Care Partner Phone: (_____) _____ - _______

Diagnosis and ICD-10 Code: ______________________

Does the patient have a documented history of poor adherence to prescribed treatment?

Yes No

Has the patient received educational efforts to improve adherence with prescribed treatment?

Yes No

Does the patient have significant clinical relapse, or are they at high risk for relapse?

Yes No

Allergies (please note reaction): ______________________

Current Medications (list here or attach): ______________________

Comorbidities (list here or attach): ______________________

Treatment History:

New to therapy Continuation of therapy

Date of Last Administration: ____ /____ /_______

Next Injection Due: ____ /____ /_______

Scan the QR code or visit otsuka-us.com/connect today

Phone Number
1-833-468-7852

Hours of Operation
Monday–Friday 8am–8pm ET

PEL Consent Form
http://pelconnect.com

Otsuka Patient Support Website
https://www.otsukapatientsupport.com

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