Coordination of Care Form

To connect with a **Patient Experience Liaison (*PEL*)** *for personalized and local support, please call Otsuka Connect at* ***1-833-468-7852****.*

Otsuka Patient Support™

Abilify Maintena® (aripiprazole) for extended release injectable suspension

Please fill out **applicable fields OR indicate that the information is attached**. When finished, fax the completed form to the selected outpatient care site or, if applicable, Integrated Pharmacy Network (IPN) member pharmacy or Local Care Center (LCC).

TO

Next Site of Care Information

Site Name: _____

Site Address: _____

Site Contact Name: _____

Site Contact Phone: (_____)_____-_____

Site Fax: (_____)_____-_____

Date of Appointment: ____/____/_____

FROM

Referring/Current Site Information

Site Name: _____

Site Address: _____

Site Contact Name: _____

Site Contact Phone: (_____)_____-_____

Prescriber Name: _____

Date of Discharge: ____/____/_____

PATIENT

Patient Name: _____ Date of Birth: ____/____/_____ Sex: ◯ M ◯ F

Phone: (_____)_____-_____ Cell: (_____)_____-_____

Address: _____ City: _____ State: _____ Zip: _____

Caregiver Name: _____ Caregiver Phone (_____)_____-_____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

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 ◯

Did the patient recieve ABILIFY MAINTENA® (aripiprazole) in the inpatient setting prior to discharge? Yes ◯ No ◯

Does the patient have significant clinical relapse, or is he or she 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:** ____/____/_____

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: _____

I.D. #: _____ RXBIN #: _____ RXPCN #: _____

Group #: _____ Plan #: _____

Secondary Insurance: _____

I.D. #: _____ RXBIN #: _____ RXPCN #: _____

Group #: _____ Plan #: _____

Medicaid #: _____

Medicare Part A Effective Date: ____/____/_____ Medicare Part B Effective Date: ____/____/_____

Otsuka Connect 1-833-468-7852

A customer-centric support network composed of dedicated professionals and enhanced digital offerings striving to deliver efficient resolution to questions and challenges.

To learn more about Otsuka Patient Support, please visit **www.otsukapatientsupport.com**

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING**.

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Confidential – Protected Health Information

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