Continuity of Care

SITE OF CARE TRANSITION FORM

Abilify Maintena®
(aripiprazole) for extended release injectable suspension

This form is made up of 2 pages. Page 1 can be used to help your patients move to their next site of care, while page 2 is for patients who need to have an ABILIFY MAINTENA® (aripiprazole) prescription filled and/or administered. You can fill out both pages OR just the page that corresponds to the offering(s) you need.

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: (_____)______-__________

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: ____________________

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 #: ____________

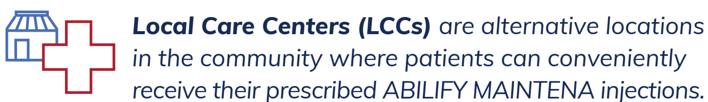
Secondary Insurance: ____________________

I.D. #: ________ RXBIN #: ________ RXPCN #: ________

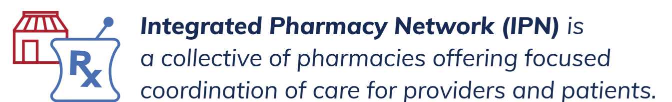
Group #: ____________ Plan #: ____________

Medicaid #: ______________________________

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



Local Care Centers (LCCs) *are alternative locations in the community where patients can conveniently receive their prescribed ABILIFY MAINTENA injections.*



Integrated Pharmacy Network (IPN) *is a collective of pharmacies offering focused coordination of care for providers and patients.*

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

Confidential – Protected Health Information

Otsuka | Lundbeck

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PRESCRIPTION FORM

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PRESCRIPTION

Verbal Prescription Phone: (_____)______-__________ Physical Prescription Fax: (_____)______-__________

E-scribe Information: ______________________________

MEDICATION: ABILIFY MAINTENA	**DISPENSE**	**QUANTITY**	**REFILLS**
◯ Dual Chamber Syringe (DCS)	◯ 300 mg	◯ 1 unit	
◯ Vial Kit	◯ 400 mg	◯ 3 units	

DIRECTIONS: ______________________________

____

PRESCRIBER

Prescriber Name: ______________________________

State License #: ______________ DEA #: ______________ NPI: ______________

Additional Contact Person Name: ______________________________

Group or Hospital: ______________________________ Phone: (_____)______-__________

Fax: (_____)______-__________ Email Address: ______________________________

Address: ______________ City: ______________ State: ______ Zip: ______________

______________ ______________ ______________

Prescriber Signature *Date* *Dispensed as Written*

DELIVERY

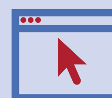
Ship To: ◯ Patient ◯ Prescriber/Clinic ◯ LCC

Phone: (_____)______-__________ Date Medication Needed: ____/____/______

Attn: ______________________________

Address: ______________________________

Patient Support Managers (PSMs) *are your main contact for Otsuka Patient Support and provide personal, on-site field support. Please contact your local PSM or call 1-855-242-7787.*



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

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

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