Continuity of Care

SITE OF CARE TRANSITION FORM

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: _____/_____/_____

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

February 2020 OPSUS20EBP0002

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Otsuka | Lundbeck

Prescription Form

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 your pharmacy of choice.

PATIENT

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

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 ○

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

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