Mobile Injection Form

Otsuka Patient Support™ | Abilify Maintena® (aripiprazole) for extended release injectable suspension

Please fill out **applicable fields OR indicate that the information is attached**. Fax the completed form to Orsini Specialty Pharmacy at (844) 687-8524 or call for assistance at (844) 687-8521.

For patients who would typically receive ABILIFY MAINTENA® (aripiprazole) injections at their prescriber's office, the COVID-19 pandemic may make it difficult to maintain their treatment schedule. Otsuka is working with Orsini Specialty Pharmacy to offer a limited-duration mobile nursing program to administer ABILIFY MAINTENA to patients identified as being at risk of missing doses due to concerns related to COVID-19. To help ensure compliance with healthcare inducement laws, Otsuka, Orsini, and their nursing service partners are not advertising this program to patients and are relying on prescribers to identify suitable patients who require support. Please note that this program is not offered for the benefit of prescribers.

PATIENT

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

ICD-10 Diagnosis Code: _____ Zip Code: _____

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	

○ Administer injection in the patient's home by a healthcare professional

Nursing visit to provide administration of ABILIFY MAINTENA by the nurse per prescriber order.

DIRECTIONS: _____

_____

DELIVERY

Delivery address must be able to receive and store medication until appointment date. Please note that deliveries may contain hypodermic needles, syringes, and/or temperature-sensitive medications. Please confirm with the patient that they or an authorized caregiver will be able to accept delivery and store securely prior to their mobile nursing appointment.

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

Attention: _____

Address: _____

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

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PRESCRIBER

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: (_____)_____-_____

Fax: (_____)_____-_____ Email Address: _____

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

CERTIFICATION STATEMENT

I, the prescriber identified on this form, am a licensed healthcare practitioner in good standing with authority to prescribe medications for the patient identified on this form. The patient has a medical need for assistance with ABILIFY MAINTENA® (aripiprazole) medication administration in the form of one or more mobile nursing service visits, in lieu of one or more office visits. Due to the COVID-19 pandemic, it is medically necessary and appropriate for the patient to receive home administration of ABILIFY MAINTENA and to my knowledge, the patient has no conditions that would contraindicate home administration. I have determined that the patient or an appropriate, authorized caregiver is willing to receive shipment(s) of ABILIFY MAINTENA, which may include one or more hypodermic needles and syringes, and to store the shipment(s) securely until the mobile nursing service appointment. I have informed the patient of their right to select their pharmacy of choice. I understand that federal healthcare program beneficiaries are not eligible for this assistance program. By signing this order form, I certify that all information listed on this form, including this certification statement, is accurate to the best of my knowledge and that the patient meets eligibility criteria.

_____ _____ _____

Prescriber Signature *Date* *Dispense as Written*

INSURANCE

PRIMARY INSURANCE INFORMATION

Insurance Name: _____

Insurance Phone: (_____) _____ - _____

Subscriber Name: _____

Subscriber ID #: _____

Group #: _____

SECONDARY INSURANCE INFORMATION

Insurance Name: _____

Insurance Phone: (_____) _____ - _____

Subscriber Name: _____

Subscriber ID #: _____

Group #: _____

Please attach a copy of both the front and the back sides of the member's insurance card.

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

September 2020 OPSUS20EBP0057

Confidential – Protected Health Information

Otsuka | Lundbeck