InfuCare Rx®

Abilify™ Enrollment Form

Fax Referral To: 877-504-3278
Phone: 877-327-8881
referrals@infucarerx.com
www.infucarerx.health

Please cut along the dotted lines before submitting to a pharmacy.

Date Required: _____ Ship To: ☐ MD Office

PATIENT INFORMATION

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Cell Phone: _____
Date of Birth: _____ Gender: _____
Emergency Contact: _____ Phone: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
Address: _____
City, State, Zip: _____
Phone: _____
Fax: _____
DEA #: _____ NPI #: _____
Contact Person: _____

INSURANCE INFORMATION (Please attach the front and back of insurance and prescription drug card.)

Primary Insurance: _____ ID: _____ Group: _____
Secondary Insurance: _____ ID: _____ Group: _____
Prescription Card: _____ ID: _____ BIN: _____ PCN: _____

To better serve your patient and facilitate insurance authorization, please complete the pertinent sections:

PATIENT DIAGNOSIS/CLINICAL INFORMATION

☐ F20 Schizophrenia
☐ F20.9 Schizophrenia, unspecified
☐ F31 Bipolar Disorder
☐ F31.9 Bipolar Disorder, unspecified
☐ Other: _____

Prior meds failed: ☐ Aripiprazole ☐ Other: _____
Length of Treatment: _____
Reason for Discontinuation: _____
Current Medications: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ cm ☐ in
Allergies: _____ ☐ NKDA
Is the patient : ☐ Inpatient ☐ Outpatient
Is the prescriber a psychiatrist? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	Dose/Strength	Instructions	Quantity	Refills
Abilify Maintena™	☐ 300mg ☐ 400mg	☐ Inject 300mg intramuscularly every 4 weeks (Qty 1) ☐ Inject 400mg intramuscularly every 4 weeks (Qty 1)		
Abilify Asimtufii™	☐ 720mg ☐ 920mg	☐ Inject 720mg intramuscularly every 8 weeks (Qty 1) ☐ Inject 920mg intramuscularly every 8 weeks (Qty 1)		
Other:				

ADDITIONAL COMMENTS

Prescriber Signature: _____ **Date:** _____

Revised 11 June 2026