

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

Date Required: _____		Ship To: _____	MD Office _____	
PATIENT INFORMATION			PRESCRIBER INFORMATION	
Patient Name: _____			Prescriber Name: _____	
Address: _____			Address: _____	
City, State, Zip: _____			City, State, Zip: _____	
Home Phone: _____			Phone: _____	
Cell Phone: _____			Fax: _____	
Date of Birth: _____ Gender: _____			DEA #: _____ NPI #: _____	
Emergency Contact: _____ Phone: _____			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		Weight: _____ kg lbs Height: _____ cm in		
F20.9 Schizophrenia, unspecified		Allergies: _____ NKDA		
F31 Bipolar Disorder		Is the patient : Inpatient Outpatient		
F31.9 Bipolar Disorder, unspecified		Is the prescriber a psychiatrist? Yes No		
Other: _____				
Prior meds failed: Aripiprazole Other: _____				
Length of Treatment: _____				
Reason for Discontinuation: _____				
Current Medications: _____				

PRESCRIPTION INFORMATION				
Medication	Dose/Strength	Instructions	Quantity	Refills
Abilify Maintena®	300mg	Inject 300mg intramuscularly every 4 weeks (Qty 1)		
	400mg	Inject 400mg intramuscularly every 4 weeks (Qty 1)		
Abilify Asimtufii®	720mg	Inject 720mg intramuscularly every 8 weeks (Qty 1)		
	960mg	Inject 960mg intramuscularly every 8 weeks (Qty 1)		
Other:				
ADDITIONAL COMMENTS				

Prescriber Signature: _____ **Date:** _____