INTRAMED Plus
infusion services

ABILIFY MAINTENA®

INFUSION & MEDICAL CENTER

1. _____ _____ _____
Patient Name **DOB** **Patient Phone/Cell #**

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please complete/select appropriate diagnosis):

Primary Diagnosis: _____ Schizophrenia ICD-10 Code: F20.9
_____ Bipolar Disorder ICD-10 Code: F31.9
_____ Other:_____ ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes & labs supporting primary diagnosis
- Recent Lab Results including any recent CBC results
- Medication List
  - Patient has previously tolerated Aripiprazole:
    - ❑ Yes ❑ **NO: Tolerability should be established prior to initiating therapy**
  - Concurrent Oral Therapy (For New Starts Only):
    - ❑ Patient to discontinue _____ after taking 14 consecutive days of concurrent therapy following the administration of their first dose of ABILIFY MAINTENA

Patient
Weight: _____ lbs.
Height: _____ in.

Infusion Center Lab Orders (Check order for Infusion center to manage):
❑ CBC at baseline and then every _____ months thereafter
❑ Other: _____

ABILIFY MAINTENA®

J Code: J0401

(aripiprazole for extended released injectable suspension)

4. Drug Order:

Administer _____mg ABILIFY MAINTENA IM monthly _____# Refills (Recommend 11 Refills)

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 800.767.6337