

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 Weight: _____ lbs. Height: _____ in.

- 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

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 CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1960
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