INTRAMED Plus
infusion services

ABILIFY®

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 IM ABILIFY

Patient
Weight: _____ lbs.
Height:_____ in.

Infusion Center Lab Orders (Check order for Infusion center to manage):

❑ CBC at baseline and then every 1-2 months thereafter concurrent with administration appointments
❑ Other: _____

4. Drug Order:

❑ Administer _____ mg ABILIFY MAINTENA (J0401) IM monthly _____# Refills (Recommend 11 Refills)

***Recommended dose is 400 mg monthly or f a dose reduction is necessary, 300 mg monthly.
Further dose adjustments may be required for certain drug-drug interactions.***

❑ Administer _____ mg ABILIFY ASIMTUFFI (J0402) IM every 2 months _____# Refills (Recommend 6 Refills)

*** Recommended dose is 960 mg every 2 months or if dose reduction is necessary, 720 mg every 2 months***

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**	**INFUSION CENTER LOCATIONS** BERKELEY CHARLESTON COLUMBIA GREENVILLE CENTRAL INTAKE PHONE 803.999.1760