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 select primary diagnosis and complete ICD-10 Code):

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:

Patient
Weight: _____ lbs.
Height: _____ in.

- Clinical MD Notes & labs supporting primary diagnosis
- Recent Lab Results including any recent CBC results
- Medication List

o Patient has previously tolerated Aripiprazole:

❑ Yes ❑ **NO: Tolerability should be established prior to initiating therapy**

o 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

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 our 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 with Credentials: _____ Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**