To: Eversana Life Science Services
17877 Chesterfield Airport Rd, Chesterfield, MO 63005
Phone: 1-855-727-6274 **Fax:** 1-844-727-6274

Otsuka PATIENT ASSISTANCE FOUNDATION

REFILL REQUEST FORM (OPAF)

ABILIFY MAINTENA® (aripiprazole) & ABILIFY ASIMTUFII® (aripiprozole)

Eversana Life Science Services is the dispensing pharmacy of the Otsuka Patient Assistance Foundation, Inc. (OPAF). Eversana will coordinate prescription refills for your patient(s). Please complete the following steps and fax back to confirm your patient's next shipment. If you have any changes or questions, please call us at 1-855-727-6274.

- Review information for accuracy.
- Confirm the Receiving Facility's name and address for shipment of the injection
- Select if the refill is for ABILIFY MAINTENA or ABILIFY ASIMTUFII.
- Confirm the prescribed dose is accurate as listed.
- Write in the date of the patient's next scheduled injection.
- Add your name to each patient that needs their prescription refilled.
- Fax this form back to 1-844-727-6274

RECEIVING FACILITY INFORMATION:

Facility Name: ____________________ Contact name: ____________________

Facility Address: ____________________ City: ____________ State: ________ Zip: ________

Facility Phone: ____________________ Facility Fax: ____________________

PATIENT INFORMATION		PATIENT DOB	PRESCRIBER INFORMATION	DATE OF NEXT INJECTION	MEDICATION		DOSE PRESCRIBED	FREQUENCY	DISPENSE METHOD	
First Name	Last Name	mm/dd/yyyy	Name	mm/dd/yyyy	ABILIFY MAINTENA	ABILIFY ASIMTUFII	(Check one)	Directions	Dual-Chamber Syringe	Vial Kit
					☐		☐ 300 mg ☐ 400 mg		☐	☐
						☐	☐ 720 mg ☐ 960 mg	EVERY TWO MONTHS	Dual-Chamber Syringe ONLY	

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE for ABILIFY MAINTENA and ABILIFY ASIMTUFII at www.abilifymaintena.com or www.abilifyasimtufiihcp. com

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REFILL REQUEST FORM (CONT'D)

Facility Name: ______________________ Contact name: ______________________

Facility Address: ______________________ City: ____________ State: ______ Zip: ________

Facility Phone: ______________________ Facility Fax: ______________________

PATIENT INFORMATION		PATIENT DOB	PRESCRIBER INFORMATION	DATE OF NEXT INJECTION	MEDICATION		DOSE PRESCRIBE D	FREQUENCY	DISPENSE METHOD	
First Name	Last Name	mm/dd/yyyy	Name	mm/dd/yyyy	ABILIFY MAINTENA	ABILIFY ASIMTUFII	(Check one)	Directions	Dual-Chamber Syringe	Vial Kit
					☐		☐ 300 mg ☐ 400 mg		☐	☐
						☐	☐ 720 mg ☐ 960 mg	EVERY TWO MONTHS	Dual-Chamber Syringe ONLY	
					☐		☐ 300 mg ☐ 400 mg		☐	☐
						☐	☐ 720 mg ☐ 960 mg	EVERY TWO MONTHS	Dual-Chamber Syringe ONLY	
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