OTSUKA PATIENT ASSISTANCE FOUNDATION, INC.
PO Box 4530, Chesterfield, MO 63006
PHONE: 1-855-727-6274; FAX: 1-844-727-6274

NEW PROVIDER ATTESTATION FORM (PAGE 1)

FOR ABILIFY ASIMTUFII® (aripiprazole)

PRESCRIPTION INFORMATION & SIGNATURES ARE REQUIRED ON PAGE 1 & PAGE 2 FOR CONTINUATION OF ENROLLMENT

I, _____, attest that I am the new prescribing provider for, _____, date of birth, _____. It is believed that this patient is actively enrolled in the Otsuka Patient Assistance Foundation, Inc (OPAF). Below I am providing my provider information and a new prescription, please update the patient's case record.

PRESCRIBER INFORMATION:

First Name: _____ Last Name: _____

State License #: _____ NPI #: _____

Direct Contact's First and Last Name: _____

Site Name: _____

Site Address: _____ City: _____ State: _____ ZIP: _____

Contact's Direct Phone: _____ Ext: _____ Contact's Fax: _____

Contact's Email: _____

PATIENT INFORMATION:

Patient First Name: _____ Patient Last Name: _____

Date of Birth (mm/dd/yyyy): _____ ICD-10 code: _____

Address: _____ City: _____ State: ___ ZIP: _____

Cell Number: _____ Email: _____

ABILIFY ASIMTUFII® (aripiprazole) PRESCRIPTION INFORMATION

PLEASE SUBMIT PRESCRIPTIONS BY ESCRIPT IF MANDATED BY INDIVIDUAL STATE LAWS. THE PRESCRIBER MUST COMPLY WITH STATE LAWS REGARDING E-PRESCRIBING, STATE-SPECIFIC PRESCRIPTION FORM, OR WRITTEN PRESCRIPTION.

If approved for assistance, will this be the patient's first administration of ABILIFY ASIMTUFII® (aripiprazole)? ☐ Yes ☐ No

ABILIFY ASIMTUFII® (aripiprazole): (Check one) ☐ 720 mg dosed every 2 months ☐ 960 mg dosed every 2 months

Dispense: Dual-Chamber Syringe ONLY

Route of Administration: Intramuscular injection in the gluteal muscle ONLY by a healthcare professional

Date of Next Injection: _____ Number of Refills: _____

I appoint the Otsuka Patient Assistance Foundation (hereafter, referred to as OPAF) to convey this prescription to the dispensing pharmacy. I certify that therapy with the above-mentioned product is medically necessary for this patient, and I have reviewed the current Prescribing Information for the prescribed product. I attest that I am not on the HHS/OIG List of Excluded Individuals and Entities and that I am presently authorized under state law to prescribe this medication. I authorize and appoint OPAF to convey on my behalf any prescription information delivered to the dispensing pharmacy. For the purposes of transmitting this prescription, I authorize OPAF and its affiliates as my agent for these limited purposes to forward this prescription electronically, or via fax, or via mail to the dispensing pharmacy. I certify that any medication received will be used only for the patient named on this application and will not be offered for sale, trade, or barter. I acknowledge that OPAF is a free goods, non-profit program that assists patients that have been approved for assistance by meeting specific criteria. I acknowledge, that at any time, I can change or withdraw this prescription on the patient's behalf due to the medical needs of the patient by calling 1-855-727-6274 or by sending a written notice to OPAF at Otsuka Patient Assistance Foundation Inc., PO Box 4530, Chesterfield, MO 63006. I understand that OPAF may revise, change, or terminate programs at any time.

☐ **Dispense as written**

Prescriber's Name: _____

Sign here _____ **Date** (mm/dd/yyyy): _____

Abilify Asimtufii® (aripiprazole) extended release suspension for injection

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE at www.abilifyasimtufiihcp.com.

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NEW PROVIDER ATTESTATION FORM (PAGE 2)
FOR ABILIFY ASIMTUFII® (aripiprazole)

Patient First Name: _____ Patient Last Name: _____

Patient Date of Birth (mm/dd/yyyy):_____

VITAMIN SUPPLEMENT

ENROLLED PATIENTS HAVE THE OPTION TO RECEIVE SELECT NATURE MADE® VITAMINS, FOR FREE FROM OPAF. PLEASE INDICATE BELOW WHAT VITAMINS YOU WOULD LIKE THE PATIENT TO RECEIVE.

☐ Biotin 2500 mcg	☐ Vitamin B1 100 mg
☐ *Calcium 600 mg	☐ Vitamin B6 100 mg
☐ Omega 1200 mg	☐ Vitamin B12 1000 mcg
☐ Folic Acid 400 mcg	☐ Vitamin C 1000 mcg (Chewable)
☐ Iron 65 mg (325 Ferrous Sulfate)	☐ Vitamin C 1000 mg
☐ Multi-Vitamin (Multi Complete)	☐ Vitamin D 50 mcg (2000 IU)
☐ Super B - Complex	☐ Vitamin E 180 mg (400 IU)
☐ Vitamin A 2400 mcg (8000 IU)	

*** Calcium 600 mg or 500 mg, depending on availability**

I appoint the Otsuka Patient Assistance Foundation (hereafter, referred to as OPAF) to convey this order to the dispensing pharmacy. I certify that therapy with the above-mentioned product is medically necessary for this patient, and I have reviewed the current Label Information for the ordered product. I attest that I am not on the HHS/OIG List of Excluded Individuals and Entities and that I am presently authorized under state law to order this medication. I authorize and appoint OPAF to convey on my behalf any order information delivered to the dispensing pharmacy. For the purposes of transmitting this order, I authorize OPAF and its affiliates as my agent for these limited purposes to forward this order electronically, or via fax, or via mail to the dispensing pharmacy. I certify that any vitamins received will be used only for the patient named on this application and will not be offered for sale, trade, or barter. I acknowledge that OPAF is a free goods, non-profit program that assists patients that have been approved for assistance by meeting specific criteria. I acknowledge, that at any time, I can change or withdraw this order on the patient's behalf due to the medical needs of the patient by calling 1-855-727-6274 or by sending a written notice to OPAF at Otsuka Patient Assistance Foundation Inc., PO Box 4530, Chesterfield, MO 63006. I understand that OPAF may revise, change, or terminate programs at any time.

Prescriber's Name: _____

Sign here _____ **Date:** (mm/dd/yyyy): _____

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