

REFILL REQUEST FORM (OPAF)
ABILIFY MAINTENA® (aripiprazole) & ABILIFY ASIMTUFII® (aripiprazole)

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
					<input type="checkbox"/>		<input type="checkbox"/> 300 mg <input type="checkbox"/> 400 mg		<input type="checkbox"/>	<input type="checkbox"/>
						<input type="checkbox"/>	<input type="checkbox"/> 720 mg <input type="checkbox"/> 960 mg	EVERY TWO MONTHS	Dual-Chamber Syringe ONLY	



Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING** and MEDICATION GUIDE for [ABILIFY MAINTENA](http://www.abilifymaintena.com) and [ABILIFY ASIMTUFII](http://www.abilifyasimtufiihcp.com) at www.abilifymaintena.com or www.abilifyasimtufiihcp.com

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
					<input type="checkbox"/>		<input type="checkbox"/> 300 mg <input type="checkbox"/> 400 mg		<input type="checkbox"/>	<input type="checkbox"/>
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