



NEW PROVIDER ATTESTATION FORM (PAGE 1)  
FOR ABILIFY ASIMTUFII® (aripiprazole)

PRESCRIPTION INFORMATION & SIGNATURES ARE REQUIRED ON 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 #: \_\_\_\_\_  
Facility Name: \_\_\_\_\_ Facility Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Facility Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
PRIMARY CONTACT: Direct Contact's First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Contact's Direct Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Contact's Email: \_\_\_\_\_

PLEASE NOTE: MISSING OR INCOMPLETE INFORMATION COULD DELAY PROCESSING

**PATIENT INFORMATION:**

Patient First Name: \_\_\_\_\_ Patient Last Name: \_\_\_\_\_  
Patient Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Gender:  M  F  Other  Decline to Specify Patient SSN: \_\_\_\_\_ Patient Date of Birth (mm/dd/yyyy): \_\_\_\_\_  
Patient Cell Number: \_\_\_\_\_ Patient Alternate Contact Number: \_\_\_\_\_  
Patient Email: \_\_\_\_\_  
Preferred Method of Contact for Our Determination:  Postal Mail  Secure Email  
*Complete if there is a primary caregiver or an alternate contact.*  
Caregiver/Parent/Legal Guardian/Alternate Contact: First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Contact Number: \_\_\_\_\_

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Please see [FULL PRESCRIBING INFORMATION](#), including BOXED WARNING and [MEDICATION GUIDE](#) at [www.abilifyasimtufiihcp.com](http://www.abilifyasimtufiihcp.com).

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

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.

Check here if you will be E-Prescribing

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

Patient First Name: Patient Last Name:

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

If NO, when was the date of patient's first medication dose?

ABILIFY ASIMTUFII® (aripiprazole): (Check one below) Dispensed via Dual-Chamber Syringe ONLY

720 mg dual chamber syringe dosed every 2 months 960 mg dual chamber syringe dosed every 2 months

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

Date of Next Injection: Refills for One Year: OR Number of Refills:

SHIP TO: (Check one)

- Prescriber Facility
My patient needs their injection administered at an alternative Local Care Center (LCC) facility. Please assist my patient in finding an LCC.
Please send my patient's injection to the alternative Local Care Center (LCC) facility for administration, indicated below:

Local Care Center Name:

Address:

City: State: Zip: Phone:

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):



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