OTSUKA PATIENT ASSISTANCE FOUNDATION, INC.
PO Box 501878, San Diego, CA 92150-1878
PHONE: 1-855-727-6274 FAX: 1-844-727-6274

NEW PROVIDER ATTESTATION FORM (PAGE 1)
FOR ABILIFY MAINTENA® (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 #: _____ Tax ID #: _____

NPI #: _____ DEA #: _____

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): _____

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

Cell Number: _____ Email: _____

ICD-10 code: _____

ABILIFY MAINTENA PRESCRIPTION:

FOR STATES WITH SPECIFIC PRESCRIPTION REQUIREMENTS, PLEASE FOLLOW STATE REGULATIONS AS REQUIRED.

ABILIFY MAINTENA® (aripiprazole): Dosage: (Check one) ☐ 300mg ☐ 400mg

Date of Next Injection: _____

Supply: (Check one) ☐ Dual-Chamber Syringe ☐ Vial Kit

Number of Refills: _____

Prescriber's Name: _____

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

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

Abilify Maintena® (aripiprazole) for extended release injectable suspension

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

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

VITAMIN PRESCRIPTION:

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	*Take one capsule daily*	Qty:	90	Refills:	
☐	Calcium 600mg (w/ 10 mcg VitD)	*Take one softgel daily*	Qty:	100	Refills:	
☐	Fish Oil 1200 mg (720mg Omega 3)	*Take one capsule daily*	Qty:	100	Refills:	
☐	Folic Acid 400 mcg	*Take one tablet daily*	Qty:	250	Refills:	
☐	Iron 65mg (325 Ferrous Sulfate)	*Take one tablet daily*	Qty:	180	Refills:	
☐	Multi-Vitamin (Multi Complete)	*Take one tablet daily*	Qty:	130	Refills:	
☐	Super B - Complex	*Take one tablet daily*	Qty:	140	Refills:	
☐	Vitamin A 2400 mcg (8000 IU)	*Take one capsule daily*	Qty:	100	Refills:	
☐	Vitamin B1 100 mg	*Take one tablet daily*	Qty:	100	Refills:	
☐	Vitamin B6 100 mg	*Take one tablet daily*	Qty:	100	Refills:	
☐	Vitamin B12 1000 mcg	*Take one capsule daily*	Qty:	90	Refills:	
☐	Vitamin C 1000 mcg (Chewable)	*Take one tablet daily*	Qty:	90	Refills:	
☐	Vitamin C 1000 mg	*Take one tablet daily*	Qty:	100	Refills:	
☐	Vitamin D 50 mcg (2000 IU)	*Take one tablet daily*	Qty:	100	Refills:	
☐	Vitamin E 180 mg (400 IU)	*Take one capsule daily*	Qty:	100	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 501878, San Diego, CA 92150-1878. 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 Maintena®
(aripiprazole) for extended release injectable suspension

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

 Confidential-Protected Health Information June 2022 PAUS22EBB0005