PRESCRIPTION FORM FOR THE ABILIFY MYCITE® KIT

AbilifyMyCite®
(aripiprazole tablets with sensor)

Please fax completed form to: 844-9-MYCITE (844-969-2483).

ONCE COMPLETED INFORMATION IS RECEIVED:

• We will begin the benefit verification process • We will contact your office and your patient with benefit verification status and next steps

For questions, contact the MYCITE® Team at 844-MYCITE-3 (844-692-4833); press 4 for pharmacy.

DATE: _____ PAGES: _____

FROM: _____ FAX #: _____

SUBJECT: **Prescription Form for the ABILIFY MYCITE Kit, with request for the following program offerings:**

- **Benefit Verification** (confirm insurance coverage and determine patient out-of-pocket costs for the ABILIFY MYCITE Kit)
- **Shipment Coordination**

Follow these steps to prescribe your patient the ABILIFY MYCITE Kit:

1. Confirm that your patient's smartphone is compatible with the ABILIFY MYCITE® System. For instructions on how your patient can see if their smartphone is compatible, please see ABILIFYMYCITE.com.

2. List the **patient's care team member(s)** with whom the patient would like to share data through the MYCITE® Dashboard.

☒ Prescriber First Name: _____ Last Name: _____ Email Address: _____

☐ Care Team Member First Name: _____ Last Name: _____ Email Address: _____

☐ Care Team Member First Name: _____ Last Name: _____ Email Address: _____

☐ Care Team Member First Name: _____ Last Name: _____ Email Address: _____

☐ Care Team Member First Name: _____ Last Name: _____ Email Address: _____

If a pre-registration form has already been submitted to the specialty pharmacy, email addresses for the prescriber and other care team member(s) are not required.

3. Provide **shipping directions**.

Each patient's first dispense of an ABILIFY MYCITE Kit will be shipped directly to your office address unless the pharmacy is otherwise instructed.

For refills, ship to:

○ My office address ○ Patient's address ○ To be determined at a later time *(the pharmacy will confirm shipping directions before processing the refill)*

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING**.

January 2020 12US20EBP0003

PRESCRIPTION FORM FOR THE ABILIFY MYCITE® KIT, cont'd

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For questions, contact the MYCITE® Team at 844-MYCITE-3 (844-692-4833); press 4 for pharmacy.

PRESCRIBER INFORMATION

First Name: _____ Last Name: _____

NPI #: _____ Email Address: _____

FACILITY INFORMATION

Facility Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____) _____ - _____ Fax #: (_____) _____ - _____

Facility Contact Name*: _____

Facility Contact Phone #: (_____) _____ - _____

*By providing a Facility Contact Name other than the Prescriber, the Prescriber is authorizing the Facility Contact to accurately relay healthcare provider direction to the pharmacy for the ABILIFY MYCITE Kit. The healthcare provider will provide appropriate oversight to ensure orders are accurately relayed and that the Prescriber is informed about all program information relevant to the clinical care of the patient.

INSURANCE ☐ Check here if attaching copies of insurance cards OR fill out this section

Primary Insurance Name: _____

Policy Holder's Name: _____ Phone #: (_____) _____ - _____

Policy #: _____ Group #: _____

Prescription Plan Name: _____

Phone #: (_____) _____ - _____ Policy #: _____

Group #: _____ BIN #: _____ PCN #: _____

PRESCRIPTION (Sign below)

☐ **Check here if a copy of prescription has been sent electronically or is attached**

Patient Name: _____ Sex: ○ M ○ F ○ Other

Patient Email: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone #: (_____) _____ - _____

DOB (MM/DD/YYYY): _____ / _____ / _____

Preferred Language: ○ English ○ Spanish ○ Other _____

Diagnosis/ICD Code: _____

List Any Known Drug Allergies: _____

ABILIFY MYCITE Kit

■ Contains a 30-day supply of ABILIFY MYCITE® (aripiprazole tablets with sensor) plus 7 MYCITE® Patches

○ 2 mg ○ 5 mg ○ 10 mg ○ 15 mg ○ 20 mg ○ 30 mg

# of Refills: _____ (dispensed monthly)

Directions: Take 1 tablet daily and replace patch weekly.

SIGN HERE _____

⦿ **Dispense as written/do not substitute** Date

SIGN HERE _____

○ Substitution accepted Date

Prescriber First and Last Name (print): _____

THIS PRESCRIPTION IS ONLY VALID IF RECEIVED BY FAX, MEETING STATE REGULATIONS.

Please see FULL PRESCRIBING INFORMATION, including **BOXED WARNING**.

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