

# Connect your patient with their next point of care

To support treatment continuity, this form can be used to refer a patient for ABILIFY MAINTENA® (aripiprazole) to alternate site(s) of care for treatment dispensing and administration.



Fax copies of patient demographic sheet, insurance information, and prescription for ABILIFY MAINTENA to the selected care site and instruct "Please dispense and administer"



Complete the Patient Transition Form on page 2 (Note: please remember to include the LAST injection due date)






Send the form to the selected outpatient care site and ASSURE Local Care Center if applicable



Provide patient with an appointment reminder card for follow-up injection appointment after discharge

The ASSURE Program™ is a suite of offerings designed to anticipate and address the support needs of appropriate patients, caregivers, and health care professionals. Our dedicated team is available to offer tools, resources, and personalized assistance to help ensure patient access to ABILIFY MAINTENA.

If you have any questions, call  1-855-242-7787 |  855-876-2627  
 Monday to Friday 8 a.m. to 8 p.m. or visit [ASSURE.com](https://www.assure.com)

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Please see [FULL PRESCRIBING INFORMATION](#), including **BOXED WARNING**.

To: \_\_\_\_\_ From: \_\_\_\_\_  
Fax Number: \_\_\_\_\_ Number of pages: \_\_\_\_\_

## Patient Transition Referral Form

The following information is being shared to keep you informed as a patient transitions to your care.  
**Attachments:**  ABILIFY MAINTENA Rx (dispense and administer)  Patient demographic information  Insurance information

### Patient Treatment History

Does the patient have a documented history of poor adherence to prescribed treatment?  Yes  No  
Has the patient received educational efforts to improve adherence with prescribed treatment?  Yes  No  
Did the patient receive ABILIFY MAINTENA® (aripiprazole) in the inpatient setting prior to discharge?  Yes  No  
Does the patient have significant clinical relapse, or is he or she at high risk for relapse?  Yes  No

### Patient Information

Patient's Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_  
Patient's Phone #: \_\_\_\_\_  
Caregiver Name/Phone #: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_

### Referring Site Information

Referring Site Name: \_\_\_\_\_  
Referring Site Address: \_\_\_\_\_  
Referring Site Contact Name/Phone #: \_\_\_\_\_  
Prescriber's Name: \_\_\_\_\_  
Date of Discharge: \_\_\_\_\_

### Receiving Site Information

Intake Site Name: \_\_\_\_\_  
Intake Site Address: \_\_\_\_\_  
Intake Site Contact Name/Phone #: \_\_\_\_\_

### Treatment Information

ABILIFY MAINTENA Injection and Dose: \_\_\_\_\_  
**Date of Last Injection:** \_\_\_\_\_  
Next Injection Due Date: \_\_\_\_\_  
**Preferred Pharmacy or ASSURE Local Care Center  
(alternative treatment location):** \_\_\_\_\_  
**Address:** \_\_\_\_\_

Completing this form does not enroll your patient in the ASSURE Program™.

*PLEASE NOTE: Patient will need to be seen by prescribing physician PRIOR to next injection due date.*

ASSURE Local Care Centers (LCCs) are alternate locations (retail pharmacies, infusion centers, etc) where patients can receive their prescribed injection from a licensed health care professional. The ASSURE Program™ can help identify LCCs that are convenient for your patients.

Please visit [www.ASSURE.com](http://www.ASSURE.com)

**ASSURE Program Managers (APMs)** focus on providing patient support and reimbursement information to support continuity of care and patient access to prescribed medications. Please contact your local APM or call 1-855-24-ASSURE (855-242-7787).

Please see [FULL PRESCRIBING INFORMATION](#), including **BOXED WARNING**.

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