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 MYCITE® App. For instructions on how your patient can see if their smartphone is compatible, please see ABILIFYMYCITE.com.

2. List the **name and email address of the patient's care team member(s)** with whom the patient would like to share data. This information will be provided to the patient during setup on their App Setup Card. Each provider must create a MYCITE® Dashboard account to connect with the patient. They can do so at RegisterMYCITE.com.

☐ 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 an email addresses for the prescriber and care team have previously been submitted to the MYCITE Team, the prescriber email address is still required, however only the first and last names of care team members are 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**.

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

AbilifyMyCite®
(aripiprazole tablets with sensor)

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

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:

Preferred Contact Name:

Contact Phone #: ( ) - Relationship to Patient:

ABILIFY MYCITE® Starter Kit

Contains a 30-day supply of ABILIFY MYCITE® (aripiprazole tablets with sensor) plus 7 MYCITE® Patches (1 data pod + 7 strips)

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

ABILIFY MYCITE® Maintenance Kit

Contains a bottle of 30 tablets of ABILIFY MYCITE and 7 MYCITE Patch strips

# of Refills: (dispensed monthly)

Directions: Take 1 tablet daily and replace patch strips weekly.

SIGN HERE Date

○ **Dispense as written/do not substitute**

SIGN HERE Date

○ Substitution accepted

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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