sage elevate

Abilify Asimtufii (Aripiprazole) Orders

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PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F

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

Phone: _____ Email: _____ Ht: _____ Wt: _____

Please Attach: ☐ Insurance cards ☐ History & Physical ☐ Most recent labs ☐ Medication list

☐ NKDA ☐ Allergies: _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____

Provider NPI: _____ Phone: _____ Fax: _____

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

REQUIRED INFORMATION

☑ Tried and Failed Medications (please specify)

_____

☑ Testing or labs

_____

MEDICATION ORDERS

ICD-10 Diagnosis Codes: ☐ F20.0 Paranoid Schizophrenia ☐ F31.81 Bipolar II disorder

☐ **Other:** _____

☐ **New to Therapy** ☐ **Continuation of Therapy:** Date of last dose (if applicable): _____

DOSING/FREQUENCY:

☑ 960 mg administered by intramuscular injection once every 2 months

☐ Other: _____ ☐ Refills: _____

Sage Infusion Standing Orders:

☑ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name	Provider Signature	Date