Opipza® (aripiprazole) oral film Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

OPI26-01

PATIENT INFORMATION

First Name	Last Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Cell Phone	

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Office Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes to support this prescription*

Patient is ☐ Naïve ☐ Previously Treated | Patient weight:_____kg

Allergies ☐ NKDA ☐ Drug Allergies (please list)

Therapies Tried (please check name and include dates)

☐ Aripiprazole Oral Solution Date ___ /____ / _____
☐ Other Atypical Antipsychotics (please list) Date ___ /____ /_____
☐ Adjunctive Antidepressants (please list) Date ____ /____ / ____
☐ Other: Date ____ /____ / ____

Current Medications (please list name and dose):

Reason(s) for Therapeutic Failure/Therapy Not Tried:
☐ Previous adverse reaction(s)
☐ Drug interaction(s)
☐ History of dysphagia
☐ Other (please list):

ICD-10 Code (Please write in)
☐ _____Schizophrenia
☐ _____Major Depressive Disorder (MDD)
☐ _____Tourette's Disorder
☐ _____Irritability associated with Autistic Disorder
☐ Other: _____

PRESCRIPTION – *please check all boxes across row*

Medication	Directions	Strength/Quantity	Refills
☐ Opipza ® (aripiprazole oral film)	*Schizophrenia (adult)* ☐ Dissolve _____mg on top of tongue once daily with or without food. *Schizophrenia (pediatric > 13 years)* ☐ Dissolve _____mg on top of tongue once daily with or without food. ☐ Other_____. *Adjunctive Treatment of Major Depressive Disorder (adults)* ☐ Dissolve _____mg on top of tongue once daily with or without food. ☐ Other_____. *Irritability associated with autistic disorder (pediatric >6 years)* ☐ Dissolve _____mg on top of tongue once daily with or without food. ☐ Other_____. *Tourette's disorder (pediatric >6 years)* ☐ < 50 kg: Dissolve _____mg on top of tongue once daily with or without food. ☐ ≥ 50 kg: Dissolve _____mg on top of tongue once daily with or without food. ☐ Other_____.	☐ 2 mg oral film ☐ 30 pouches ☐ ___ pouches ☐ 5 mg oral film ☐ 30 pouches ☐ ___ pouches ☐ 10 mg oral film ☐ 30 pouches ☐ ___ pouches	☐ 11 ☐ _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*