

**Physician Request Form for Risperdal-Consta®**

Fax non-urgent requests to PerformRx Pharmacy Services at **866-369-6041** or urgent requests to **866-533-5497**. Urgent requests should be reserved for those situations in which applying the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **866-369-6037**. **Form must be completed for processing.**



Patient Name: \_\_\_\_\_ Plan ID#: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs = \_\_\_\_\_ Kg Birth Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI #: \_\_\_\_\_  
Address: \_\_\_\_\_ Apt # or Suite #: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Dosage: \_\_\_\_\_, Frequency of administration: \_\_\_\_\_, Start Date or Dates of treatment: \_\_\_\_\_

Is the member/patient currently residing in a Long-Term Care (LTC) facility? (please check)  Yes  No

For **initial therapy** request please fill out **Part A**, for **renewal request** please fill out **Part B**.

Four weeks of therapy (2 injections) will be approved with 3 refills for initial and reauthorization requests. Contact the pharmacy to have refills processed and medications shipped to the office. Allow 2 business days for delivery.

**Part A- Attach Additional Information As Necessary**

- 1. Diagnosis: \_\_\_\_\_
- 2. Does the patient have a history of noncompliance with the prior oral anti-psychotic regimen? (circle answer) Yes or No or N/A

If yes, has the patient been on a drug adherence plan and/or have attempts been made to improve the patients' compliance (i.e. reminders, self-monitoring tools)? Yes or No

If Yes, please attach adherence treatment plan or document what adherence measures were done in an attempt to improve compliance:

- 3. Has the patient in the past received at least 2 mg of oral Risperdal® without any significant side effects? (circle answer) Yes or No

If no, please indicate the complications and provide documentation as needed:

- 4. Does the patient have renal and/or hepatic impairment? (circle answer) Yes or No

If yes, please provide documentation indicating the patient has been able to tolerate at least 2 mg of Risperdal® therapy:

**Part B- Attach Additional Information As Necessary**

- 1. Has the patient been receiving and tolerating Risperdal-Consta® therapy (please attach documentation as needed)? (circle answer) Yes or No

If no, please explain:

- 2. Provide documentation indicating how the patient has clinically benefited from Risperdal-Consta