

**Physician Request Form for Long-Acting Injectable Atypical Antipsychotics**

Risperdal Consta (Risperidone): 12.5 mg/2ml, 25 mg/2ml, 37.5 mg/2ml, 50 mg/2ml

Invega Sustenna (Paliperidone): 39mg, 78mg, 117mg, 156mg, 234mg

Fax non-urgent requests to PerformRx Pharmacy Services at **877-693-8280** or urgent requests to **877-693-8476**. Urgent requests should be reserved for situations in which the standard procedure may seriously jeopardize the enrollee's life, health, or ability to regain maximum function. To speak to a representative, call **800-578-0898**. *Form must be completed for processing*

Patient Name: \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

NPI #: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Drug Name: \_\_\_\_\_ Dosage: \_\_\_\_\_, Frequency of administration: \_\_\_\_\_

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

Diagnosis: \_\_\_\_\_ LTC member  Yes  No, Date Admitted \_\_\_\_\_

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

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

1b. Does the patient have a high risk for decompensation/functional impairment (i.e., hospitalizations, safety risk)? **(circle answer)** Yes or No

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:**

\_\_\_\_\_

2. Has the patient in the past received oral Risperdal® or Invega® without any significant side effects? **(circle answer)** Yes or No

If yes, please indicate which medication at the dose given. If no, please indicate the complications and provide documentation as needed:

\_\_\_\_\_

3. For patients requesting Invega Sustenna, has the member tried & failed Risperdal Consta? **(circle answer)** Yes or No

\_\_\_\_\_

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

If yes, for patients requesting Risperdal Consta, 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 treatment (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 the treatment:

\_\_\_\_\_