Physician Request Form for Long-Acting Injectable 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**.
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 #: __________ Height: ________ Weight: ________lbs = ________Kg 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: ______________________

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:

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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:

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

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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:

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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:

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