



Fax to PerformRx at **1-855-851-4058**, or call **1-866-907-7088**. *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: _____

Diagnosis: _____

Deliver to:

Participant's Home Physician's Office Participant's Preferred Pharmacy (Name/Phone#): Sunray Specialty Pharmacy 215-471-4000 x0

I acknowledge that the Participant agrees with the pharmacy chosen for delivery of this medication.

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

Part A- Attach Additional Information as Necessary

1. 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:

2. Has the patient in the past received oral Risperdal or oral 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. 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: