Physician Request Form for Long-Acting Injectable Atypical Antipsychotics

Fax to PerformRx at **215-937-5018**, or to speak to a representative call **800-588-6767**. ***Form must be completed for processing.***

Keystone First

Sunray Specialty Pharmacy

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:

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

☒ I acknowledge that the member 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:

_____

_____