

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

Fax non-urgent requests to PerformRx Pharmacy Services at 866-369-6038

or urgent requests to **866-533-5491**. 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 **866-533-5490**. **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**.

**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:

\_\_\_\_\_

2. Has the patient in the past received oral medications (i.e. 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. Has the patient in the past received any long acting injectable medications (i.e. Risperdal Consta or Invega Sustenna)? (circle answer) Yes or No

\_\_\_\_\_

**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  
no, please explain:

\_\_\_\_\_

2. Provide documentation indicating how the patient has clinically benefited from the treatment:

\_\_\_\_\_

