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

KEYSTONE MERCY HEALTH PLAN
A Program of Keystone First and Mercy Health Plan

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: ______________________

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:

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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:

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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

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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:

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

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