Health Partners Plans

# HEALTH PARTNERS PLANS
## *PRIOR AUTHORIZATION REQUEST FORM*

Risperdal Consta® (Risperidone)

**Phone: 215-991-4300** **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** | |
|---|---|---|
| Member Number: | Fax: | Phone: |
| Date of Birth: | Office Contact: | |
| Address: | NPI: | State Lic ID: |
| City, State ZIP: | Address: | |
| Primary Phone: | City, State ZIP: | |
| Line of Business: □ Medicaid<br>□ CHIP | Specialty/facility name (if applicable): | |

□ Expedited/Urgent

**Drug Name**:
**Strength:**
**Directions / SIG:**

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
**Please answer the following questions and sign.**

Q1. What is the patient's age?

☐ Less than 18 years
☐ Equal to or greater than 18 years

Q2. What is the patient's diagnosis?

☐ Schizophrenia ☐ Bipolar I Disorder ☐ Other

Q3. If other, please provide the diagnosis below.

Q4. Has the patient been started on Risperdal Consta while inpatient? Please provide discharge summary with date of last injection.

☐ Yes ☐ No

Q5. Has the patient tolerated treatment with oral risperidone without side effects? Please include dose and indicate complications, if any.

☐ Yes ☐ No

Q6. After three weeks, will you discontinue treatment of previous oral atypical antipsychotic(s)? Please attach treatment plan.

☐ Yes ☐ No

Q7. Does the patient have a history of long-term non-compliance with oral antipsychotic medication and/or documented medical reason which would prevent the patient from using oral formulary atypical antipsychotic medication?

☐ Yes ☐ No

Q8. Has the patient failed measures (such as psychosocial interventions, psychoeducational interventions that have a behavorial component and supportive services, and providing patient with instructions and problem-solving strategies

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such as reminders, self-monitoring tools, cues, and reinforcements) to improve compliance with formulary oral medications? Please submit documentation.

☐ Yes ☐ No

Q9. Has the patient had repeat relapses (i.e. hospital admissions) related to diagnosis? Please indicate dates and duration.

☐ Yes ☐ No

Q10. Requested duration:

☐ 12 months ☐ Other:_____

Q11. Additional Information:

_____ _____

Prescriber Signature Date

Updated 2015