



**HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM**

Health Partners Plans

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: <input type="checkbox"/> Medicaid <input type="checkbox"/> 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? <input type="checkbox"/> Less than 18 years <input type="checkbox"/> Equal to or greater than 18 years
Q2. What is the patient's diagnosis? <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar I Disorder <input type="checkbox"/> 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. <input type="checkbox"/> Yes <input type="checkbox"/> No
Q5. Has the patient tolerated treatment with oral risperidone without side effects? Please include dose and indicate complications, if any. <input type="checkbox"/> Yes <input type="checkbox"/> No
Q6. After three weeks, will you discontinue treatment of previous oral atypical antipsychotic(s)? Please attach treatment plan. <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q8. Has the patient failed measures (such as psychosocial interventions, psychoeducational interventions that have a behavioral 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