



PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Risperdal Consta® (Risperidone)

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

HEALTH PARTNERS 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 print clearly.**

Patient Name:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Physician Name:

Fax:

Phone:

Office Contact:

NPI:

State Lic. Id:

Address:

City, State, Zip:

Drug Name:

Expedited/Urgent

Directions:

Please answer the following questions and sign below:

Q1. What is the requested duration of therapy?
6 months or less More than 6 months

Q2. Documentation indicates that Risperdal Consta continues to be prescribed for its FDA approved indication of schizophrenia.
Yes No

Q3. Has the patient clinically improved or remained stable while receiving Risperdal Consta?
Yes No

Q4. Is the patient adequately tolerating the medication?
Yes No

Q5. Deliver to:
Physician's Office Home Delivery

Q6. Delivery date needed:

Physician Signature

Date