



# Prior Authorization Request Form for Risperdal® Consta®

Please fax all Prior Authorization requests for medications to the Magellan Pharmacy Helpdesk at **866-498-0628**  
 Only one medication request per form • All fields must be complete and legible for review  
*If the request is urgent, please call 800-790-1631.*

All requests for reconsideration, regardless of reason, should be faxed to 866-498-0628 clearly marked "Reconsideration Request"

PRESCRIBER	PRESCRIBER NPI	RECIPIENT	RECIPIENT ID NUMBER (CIS OR AHCCCS ID)
	PRESCRIBER NAME		RECIPIENT NAME
	PRESCRIBER SPECIALTY		RECIPIENT DATE OF BIRTH (MM/DD/YYYY)
	CLINIC NAME		<input type="checkbox"/> FEMALE <span style="margin-left: 200px;"><input type="checkbox"/> MALE</span>
	OFFICE PHONE		RECIPIENT SEX (CIRCLE)
	OFFICE FAX		Height (inches) _____ Weight (lbs) _____
CONTACT NAME	<b>RECIPIENT HAS A DIAGNOSIS OF:</b> <input type="checkbox"/> Schizophrenia <span style="margin-left: 100px;"><input type="checkbox"/> Bipolar Disorder Type 1</span> <input type="checkbox"/> Schizophreniform Disorder <span style="margin-left: 100px;"><input type="checkbox"/> Other (document below)</span> <input type="checkbox"/> Schizoaffective Disorder		

REQUEST	<b>RISPERDAL® CONSTA®</b>	<b>IM</b>	<b>BIWEEKLY</b>	
	MEDICATION NAME	STRENGTH AND FORM	ROUTE OF ADMINISTRATION	FREQUENCY
	DATE THERAPY INITIATED (MM/DD/YYYY)	EXPECTED LENGTH OF THERAPY	QUANTITY PER FREQUENCY	

RATIONALE FOR EXCEPTION OR PRIOR AUTHORIZATION	<i>Please indicate "YES" or "NO" to the following questions:</i>	
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Is the recipient at least 18 years old?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Can the recipient tolerate at least 2mg/day of oral risperidone?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Does the recipient have a documented history of poor adherence to oral risperidone?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Have recipient education and other efforts to improve adherence to oral risperidone been tried (e.g. counseling with a Peer Medication Coach or Medi-Set training)?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	The recipient is not currently on oral risperidone, or, if they are on oral, they will discontinue oral risperidone within 60 days after Risperdal® Consta® is initiated?
	<input type="checkbox"/> YES <input type="checkbox"/> NO	Are target symptoms clearly documented and tracked over time in the psychiatric progress notes and assessments?
	DOCUMENT OTHER RATIONALE FOR TREATMENT	
PRESCRIBER'S SIGNATURE	DATE	

*By signing this form, the prescriber is attesting that documentation supporting the above information is recorded in the Patient's Medical Chart.*

Confidentiality Notice: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender (Via return FAX) immediately and arrange for the return or destruction of these documents

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