ProCare Rx

Risperdal Consta® risperidone

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Risperdal Consta® risperidone. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information

Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information

Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information

Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. Did a psychiatrist prescribe this medication? YES NO
2. What is the patient's diagnosis?
   - ☐ Schizophrenia
   - ☐ Bipolar Disorder
3. Does the patient have a documented history of medication non-compliance/non-adherence? (check all that apply) YES NO
   - ☐ Noncompliance with treatment as defined by DSM-TR
   - ☐ Noncompliance, which has also resulted in significant decompensation
   - ☐ There is a high risk for decompensation and functional impairment, e.g. hospitalization, safety risk
4. Does this patient have a documented tolerance to oral risperidone? YES NO
5. Is willingness to accept medication documented as a target on the individual's Treatment Plan? YES NO
6. Are psychosocial interventions being implemented, as clinically applicable, as components of this patient's Treatment Plan? YES NO
7. Is the patient being provided with concrete instructions and problem-solving strategies, such as reminders, self-monitoring tools, cues and reinforcements? YES NO
8. Since problems with adherence are recurring, are booster sessions implemented to reinforce and consolidate gains? YES NO

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.