

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?	<input type="checkbox"/> Schizophrenia <input type="checkbox"/> Bipolar Disorder		
3. Does the patient have a documented history of medication non-compliance/non-adherence? (check all that apply)	<input type="checkbox"/> Noncompliance with treatment as defined by DSM-TR <input type="checkbox"/> Noncompliance, which has also resulted in significant decompensation <input type="checkbox"/> There is a high risk for decompensation and functional impairment, e.g. hospitalization, safety risk	YES	NO
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:

MC-Rx 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.

Prior authorization forms are reviewed at least annually and are available at www.MC-Rx.com. Medical Review Criteria are reviewed at least annually. Revised 5/2019