CMSP
COUNTY MEDICAL SERVICES PROGRAM

MedImpact Healthcare Systems, Inc.

Risperdal Consta Medication Request Form

Phone: 1-800-788-2949, Fax: 858-790-7100

Instructions: Please complete this form and fax to Med**Impact** Healthcare Systems, Inc. at (858) 790-7100.

Patient Name (**required**):	Patient ID # (**required**):	Patient DOB (**required**):
Physician Name(**required**):	Physician DEA Number:	Physician Specialty:
Physician Area Code and Telephone Number (**required**): ( ) -	Physician Area Code and Fax Number (**required**): ( ) -	
Strength (**required**):	Dose (**required**):	
Diagnosis (**required**):	ICD-9 Code (**required**):	

Initial Requests (For renewal requests, skip to "Renewal Requests")

1. Has the patient tolerated a trial of oral risperidone (Risperdal)? ☐ YES ☐ NO
2. Has the patient's condition improved on a trial of oral risperidone (Risperdal)? ☐ YES ☐ NO
3. Does the patient have a documented history of noncompliance with therapy? ☐ YES ☐ NO
4. Please check the statement that describes how Risperdal Consta will be available for administration at the clinic.
   - ☐ Patient will fill the prescription for Risperdal Consta at the pharmacy and bring the drug to the clinic appointment.
   - ☐ The clinic staff will arrange for the filled prescription to be delivered to the clinic for administration to the patient.
   - ☐ The clinic staff will pick up the filled prescription at the pharmacy and bring it to the clinic for administration to the patient.
   - ☐ Other: _____
5. Will the clinic staff arrange for proper temperature storage of the requested agent? ☐ YES ☐ NO
6. Does the provider agree to have the following parameters monitored at each clinic appointment? ☐ YES ☐ NO
   - Number of acute schizophrenic episodes
   - Changes in grooming and hygiene
   - Changes in patterns of speech
   - Level of suspiciousness
   - Belief that others want to harm him/her
   - Adherence to scheduled appointments for Risperdal Consta administration
   - Adverse effects of therapy

Renewal Requests

1. In the previous 3 months, how many appointments has the member missed for administration of Risperdal Consta? _____missed appointments
2. Since initiating Risperdal Consta therapy, has the patient had an increase in hospitalizations for schizophrenic episodes? ☐ YES ☐ NO
3. In the previous 3 months, the patient had improvement of the following parameters: (check all that apply)
   - ☐ Changes in grooming and hygiene
   - ☐ Changes in patterns of speech
   - ☐ Level of suspiciousness
   - ☐ Belief that other want to harm him/her
4. Has the patient developed extrapyramidal effects or has the patient experienced a worsening of extrapyramidal effects while on Risperdal Consta therapy? ☐ YES ☐ NO
5. How long has the patient been on Risperdal Consta therapy?
6. Please provide any additional medical justification for renewal, if applicable.

Name of provider/case manager: (please print) _____

Signature of provider/case manager (required):_____ **Date:**

_____