Magellan HEALTHCARE℠

Risperdal Consta Injection Request Form
Fax to Magellan: 1.888.656.4916

(All requests must be approved in advance to insure authorization)

Today's Date: _____

Member Name: _____ Medicaid ID #: _____

Provider: _____ Contact: _____

Contact Phone Number: _____ Provider MIS #: _____

Current Diagnosis: ☐ Schizophrenia ☐ Bipolar Disorder ☐ Other (please explain below:

_____

Is the member over age 18? ☐ Yes ☐ No Is the member over age 65? ☐ Yes ☐ No
Dementia related psychosis? ☐ Yes ☐ No

What are the member's specific symptoms that are being targeted with this treatment?

_____

_____

_____

The Member's ability to tolerate extended exposure to Risperdal has been established by the use of oral Risperdal (including M-Tabs), prior to the Member receiving Risperdal Consta. Please list dates and doses of Risperdal exposure:

_____

_____

There is clear documentation that the Member cannot take oral Risperdal. Include Member-specific reasons why Risperdal Consta is expected to be effective, even when oral Risperdal (including Risperdal M-Tabs) was not:

_____

There is clear documentation that the Member cannot be treated with Haldol Decanoate or Prolixin Decanoate:

_____

_____

_____

_____

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There is clear documentation that the Member has been prescribed several oral antipsychotic medications, but could not be safely and effectively treated with any of those medications.
☐ Yes ☐ No (explain below)

_____

_____

_____

The Member has agreed to receive the injections on a regular basis, at the interval prescribed, and a person or agency that is geographically accessible and capable of dispensing the injections at the required frequency has been identified. ☐Yes ☐No

Recent laboratory tests (CBC, lipid panel, FBS) have been completed and reviewed:
☐ Yes Date reviewed: _____ ☐ No

Results:

_____

_____

The maximum FDA approved dosage is 50mg every 2 weeks. Amounts in excess of this dose and frequency have not been shown to have additional efficacy, so will not be authorized.

Please list all current medications and doses:

Medication:	Dosage:

Dosage Information for Authorization:
Please authorize for: _____ months or _____ injections.
Dosage given on each appointment date: _____(mg)__

Dates of injections:

J2794 (Risperdal Consta) x _____ Units (0.5 mg = 1 unit)
96372 (injection) x_____ (number of injections)

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