Physician Request Form for Long-Acting Injectable Atypical Antipsychotics
Fax to PerformRx at **855-811-9332**, or to speak to a representative call **888-602-3741**. *Form must be completed for processing.*

Patient Name: ______________________________ Patient ID#: ____________
Address: ______________________________ Apt # or Suite #: ____________
City: ____________________ State: ____________ Zip Code: ____________
Phone #: ____________ Weight: ________ lbs = ________ Kg Birth Date: ____________

Physician Name: ______________________________ NPI #: ____________
Address: ______________________________ Apt # or Suite #: ____________
City: ____________________ State: ____________ Zip Code: ____________
Contact Person: ____________________ Phone #: ____________ Fax #: ____________

Drug Name: ____________________ Dosage: ____________ Frequency: ____________
Diagnosis: ____________________
Please indication where medication is being administered: ☐Physician Office ☐Other (Please specify): ____________

Part A (Initial Therapy Request) - Attach Additional Information as Necessary

1. Does the patient have a long term history of noncompliance (>3 months) with the prior oral anti-psychotic regimen? ☐Yes* ☐No**

*If yes, has the patient been on a drug adherence plan and/or have attempts been made to improve the patient's compliance (i.e. problem-solving strategies, reminders, self- monitoring tools, cues, reinforcements, supportive services, etc)? ☐Yes ☐No
If Yes, please attach adherence treatment plan or document what adherence measures were done in an attempt to improve compliance: ____________

**If no, does the patient have a documented medical reason for not using oral formulary atypical antipsychotic medications? ☐Yes ☐No
If yes, please document the reason: ____________

2. Has the patient had clinical decompensation or is the patient at high risk of clinical decompensation and functional impairment (e.g. hospitalizations, safety risk, repeated relapses related to diagnosis)? ☐Yes* ☐No
*If yes, please describe: ____________

3. Has the patient demonstrated tolerability to the oral agent of the drug that is being requested without any significant side effects? ☐Yes ☐No

4. If the request is for Risperdal Consta or a long acting Invega product? ☐Yes ☐No*
*If no, please provide medical reason why these agents have not been or are not able to be used: ____________

5. If request is for Invega Trinza, has been stable on Invega Sustenna for 4 months and at the same dose for the last 2 months. Provide dates and dosing: ____________

Part B (Renewal Request) - Attach Additional Information as Necessary

1. Has the patient been compliant with filling their medication? ☐Yes ☐No*
   *If no, please document why the member missed dosing: ____________
2. Provide documentation that the member is stable on medication: ____________

Prescriber signature: ______________________________ **Date:** ____________