45 Earhart Drive, Suite 110, Amherst, NY 14221

RISPERDAL CONSTA AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name	First Name	Today's Date	Date Needed
Parent/Guardian		Prescriber	Hospital/Clinic
Home Phone Number ( )	Work Phone Number ( )	Phone Number ( )	Fax Number ( )
Home Address	City State Zip	Address	City State Zip
Ship To: ☐ Prescriber ☐ Patient's Home Language Preference ☐ English ☐ Spanish ☐ Other		Office Contact	Prescriber Speciality
Known Allergies:		Contact Preference ☐ Phone ☐ Fax ☐ Email: ______	
Weight ______ Lbs. Height ____ Ft _____ In	Date of Birth ___ / ___ / ___ Sex ☐ M ☐ F	Special Instructions	

INSURANCE INFORMATION
Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: ____________________
Name of Insured: ____________________
Policy #: ____________________
Group #: ____________________
Phone #: ____________________
Rx Drug Card #: ____________________

Secondary Insurance: ____________________
Name of Insured: ____________________
Policy #: ____________________
Group #: ____________________
Phone #: ____________________
Rx Drug Card #: ____________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ____________________

ICD9 Code: ____________________

Hx of Medications Tried and Failed: ____________________

Does patient have documented tolerability and efficacy to oral risperidone? ☐ Yes ☐ No

Does patient have a documented compliance problem with oral risperidone therapy? ☐ Yes ☐ No

DRUGNAME: RISPERDAL CONSTA

☐ New Authorization ☐ Re-authorization*

Dose: ____________________

Frequency: ____________________

Expected duration of therapy: ____________________

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