SEND TO BANKS APOTHECARY FAX (215) 357 2129

Physician Request Form for Long-Acting Injectable Atypical Antipsychotics.

Patient Name: ____ Patient ID#: ______________________________________

Address: ____ Apt # or Suite #: ____________________________

City: ____ State: ________________ Zip Code: _________________________________

Phone #: _______________________________________ Birth Date: _________________________________

Physician Name: ____ NPI #: ______________________________________

Address: ____ Apt # or Suite #: ______________________________

City: ____ State: ___________ Zip Code: ___________________________________

Contact Person: ________________________________ Phone #: _________________ Fax #: ______________________________________

➔ Physician Signature: ____ Date: _____________________________

Drug Name: _________________________________**Dosage**:______________________, **Frequency of administration**:_____________________________

Diagnosis: ____ **REFILL AMOUNT**_______________

Please indicate where the medication is being administered: **(BANKS APOTHECARY)**

For **initial therapy** request please fill out **Part A**. For **renewal request** please fill out **Part B.**

Part A- Attach Additional Information as Necessary

1. Does the patient have a history of noncompliance with the prior oral anti-psychotic regimen? **Yes** **No** **N/A**
If yes, has the patient been on a drug adherence plan and/or have attempts been made to improve the patients' compliance (i.e. reminders, self-monitoring tools)? **Yes** **No**
If Yes, please attach adherence treatment plan or document what adherence measures were done in an attempt to improve compliance:

____

____

2. Has the patient in the past received oral Risperdal→ or oral Invega→ without any significant side effects? **Yes** **No**
If yes, please indicate which medication at the dose given. If no, please indicate the complications and provide documentation as needed:

____

____

3. Does the patient have renal and/or hepatic impairment? **Yes** **No**
If yes, for patients requesting Risperdal Consta, please provide documentation indicating the patient has been able to tolerate at least 2 mg of Risperdal→ therapy

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Part B- Attach Additional Information as Necessary

1. Has the patient been receiving and tolerating treatment (please attach documentation as needed)? **Yes** **No**
If no, please explain:

____

2. Provide documentation indicating how the patient has clinically benefited from the treatment:

____

____

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BANK'S APOTHECARY

Specialty Pharmacy

Phone (215) 494 9403 • Fax (215) 357 2129

BANKS APOTHECARY FOLLOW UP FORM

PATIENT ______________________________

DOB ______________________ TODAY'S DATE ______________

DATE OF NEXT INJ ______________________________

DATE OF LAST INJ ______________________________

CONTACT PERSON ______________________________

PHONE NUMBER ______________________________

FAX NUMBER ______________________________

EMAIL ADDRESS ______________________________

ADDITIONAL NOTES ______________________________

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