

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049



## **Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Risperdal® (risperidone): Quantity Limit Exception Form: Please respond.

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- Please complete the attached Risperdal® (risperidone) Quantity Limit Exception Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient's treatment. Supporting documentation is available in the patient's record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

### Information about this drug

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#### Risperdal® (risperidone)

A significant dose-related increase in extrapyramidal symptoms (EPS) occurs when doses exceed 6mg/day without increased efficacy in clinical trials. Expert consensus statements from the J Clin Psychiatry recommend that the acute treatment dose should be between 4.0 - 6.5 mg/day, while the dose in patients greater than or equal to 65 years of age should be limited to 1.5 -3.5 mg/day. Target dose recommended in treatment-resistant patients of 6 - 10 mg/day. The maximum daily dose under our quantity limit program is 8 mg/day.

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

Last Updated: 01/22/2008

M0018\_PATEMP\_1107 CMS 11/28/07 H5656

# Quantity Limit Exception Form



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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Risperdal® (risperidone) Criteria

- 1 Please indicate product requested:
  - Risperdal® tabs
  - Risperdal M® tabs
  - Risperdal® oral solution
  - For Risperdal Consta® requests, please complete Risperdal Consta® PA form.
- 2 Please indicate the patient's diagnosis. Select or specify the correct ICD-9 code. This question must be completed
  - Schizophrenia or other chronic psychotic disorders
  - Bipolar Disorder
  - Behavioral disturbances in the elderly that impair functional ability
  - Other (diagnosis and ICD-9) \_\_\_\_\_
- 3 Is the patient currently taking Risperdal?  
 Yes  No
- 4 Is the patient greater than or equal to 65 years old?  
 Yes  No
  - If the answer to question #6 was yes, then answer the following:
- 5 Is the patient compliant to the medication regimen (taken 95% of doses in last 30 days)?  
 Yes  No
- 6 How long has the current dose been used?  
 < 1 month  > 1 month
- 7 Please indicate which of the following best describes your patient's antipsychotic regimen:
  - The patient is receiving an enzyme inducer (e.g., carbamazepine)
  - The patient receiving more than one atypical antipsychotic agent and is not in the process of dosage cross titration
  - The patient received a partial response and is tolerating the current dose.
  - A lipid panel, fasting glucose, weight, BMI, and BP and should be evaluated prior to initiation & periodically thereafter.

Medical justification: (Attach additional page if necessary): \_\_\_\_\_  
\_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_