sage elevate

RISPERDAL CONSTA *(risperidone)* Orders

intake@sage-elevate.com | Phone/Fax: (813) 683-5963
www.sage-elevate.com/SubmitOrder

PATIENT INFORMATION

Patient Name: _____ **DOB**: _____ **Gender:** ☐ M ☐ F

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone: _____ **Email:** _____ **Ht:** _____ **Wt:** _____

Please Attach: ☐ Insurance cards ☐ History & Physical ☐ Most recent labs ☐ Medication list

☐ **NKDA** ☐ **Allergies:** _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____

Practice Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

REQUIRED INFORMATION

Documentation:

☐ Recent clinical and/or office visit notes supporting primary diagnosis

☐ Tried and Failed Medications: _____

Has the patient established tolerability on oral RISPERDAL prior to initiating treatment? ☐ YES ☐ NO

MEDICATION ORDERS

ICD-10 Diagnosis Codes:

☐ **F20.9** Schizophrenia, unspecified

☐ **F31.9** Bipolar disorder, unspecified

☐ **Other** _____

☐ **New to Therapy** ☐ **Continuation of Therapy:** Date of last dose (if applicable): _____

Dosing/Frequency:

☑ **Risperdal Consta administered as deep intramuscular (IM) gluteal or deltoid injection.**

Every 2 weeks : ☐ 25 mg ☐ 37.5 mg ☐ 50 mg

☐ **Refills:** _____

☑ Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name	Provider Signature	Date