



**Non-Formulary Drug Use Request:
Risperidone Consta, Aripiprazole Maintena,
Paliperidone Sustenna**

DATE

PHYSICIAN'S NAME	FACILITY	
PATIENT'S NAME	MRN	WARD

EXISTING DIAGNOSIS

I. Medication Requesting

Check one: Risperidone Consta Aripiprazole Maintena Paliperidone Sustenna
(Some patients may be responsible for significant copays upon discharge.)

II. Drug Use Guidelines

Check "Yes" or "No."	YES	NO
1. Patient has a documented positive response to immediate-acting risperidone or aripiprazole.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Patient has a documented history of non-adherence.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Patient is anticipated to be discharged from the hospital within four months (required for Sustenna) If "No," indicate reason here:	<input type="checkbox"/>	<input type="checkbox"/>
4. Tolerance to greater than or equal to 2 mg/day oral risperidone or greater than or equal to 10 mg/day oral aripiprazole.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Supplemental doses of oral antipsychotics will be allowed until a patient stabilizes on the long-acting injection or experiences breakthrough symptoms. It is advised to continue oral risperidone for three (3) weeks after starting Consta. It is not necessary to continue oral after starting sustenna. It is advised to continue oral aripiprazole for two (2) weeks after starting Maintena.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Carbamazepine must be discontinued prior to administration of Consta, Maintena, or Sustenna because it decreases the serum level and efficacy of these drugs by up to 50%	<input type="checkbox"/>	<input type="checkbox"/>

PHYSICIAN'S SIGNATURE	DATE
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III. Pharmacist's Review

Check one: Approve Disapprove
Reason:

PHARMACIST'S SIGNATURE	DATE
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IV. Chief Medical Officer: not required unless a disagreement between MD / Pharmacist exists.

Check one: Approve Disapprove
Rationale:

MEDICAL DIRECTOR / DESIGNEE / SUPERVISOR'S SIGNATURE	DATE
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