



15 Earhart Drive, Suite 101, Amherst, NY 14221

INVEGA SUSTENNA AUTHORIZATION AND RE-AUTHORIZATION REQUEST

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

Member Name:		Today's Date:		Date Needed:	
Date of birth:		Sex:		Prescriber:	
				Specialty:	
Home Phone Number:		Phone Number:		Fax Number:	
()		()		()	
Home Address:		City:		State:	
		Zip:		Address:	
				City:	
				State:	
				Zip:	
Payor:		<input type="checkbox"/> Commercial <input type="checkbox"/> Medicare		Notes:	
<input type="checkbox"/> Independent Health		<input type="checkbox"/> Medicaid <input type="checkbox"/> Self-funded			
<input type="checkbox"/> Anne Arundel Health System				Allergies:	
<input type="checkbox"/> Pharmacy Benefit Dimensions					
Insurance ID:		Group Number:			

DRUG NAME: INVEGA SUSTENNA

New Authorization Re-authorization*

Dose: _____

Frequency: _____

Primary Diagnosis: _____

ICD10 Code: _____

Authorization request is coming from a psychiatrist (or under the documented recommendation of a psychiatrist)

Patient is diagnosed with schizophrenia

OR

Patient is diagnosed with Schizoaffective disorder

Using as monotherapy

Using as an adjunct to mood stabilizers or antidepressants

STATEMENT OF MEDICAL NECESSITY

Serum creatinine level submitted Date: _____

Weight: _____ Date: _____

Patient has documented tolerability and efficacy of oral paliperidone or oral/injectable risperidone

Patient has a documented compliance problem with oral paliperidone therapy or risperidone therapy.

Injection will be administered by a healthcare professional