reliance|rx℠
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:	
Member's Insurance ID:	Office Contact:	
Allergies:		

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