Statement of Medical Necessity Information Form for Invega Trinza™

Fax the completed form requesting Invega Trinza™ and chart notes to 1-800-424-5851 for review.

In order to complete the review for the requested PA, all questions must be answered on the form and the prescriber is required to submit chart notes with this completed form.

Beneficiary Information

LAST NAME: | **FIRST NAME:**

MEDICAID ID NUMBER: | **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: | **FIRST NAME:**

NPI NUMBER: | **DEA NUMBER:**

PHONE NUMBER: – – | **FAX NUMBER:** – –

Clinical Criteria Documentation *****Do **not** include documentation that is not requested on this form*****

1. If this is initial request for Invega Trinza™, how long has the beneficiary received Invega Sustenna®: _____
2. Provide the following information regarding the last 4 administration dates of Invega Sustenna®:

	List Last 4 Administration Dates Of Invega Sustenna®:	Name Of Person(s) Administering Injection(s):	Facility Name Where Injection Administered:
1)			
2)			
3)			
4)			

3. What is the diagnosis being treated? _____
4. Explain stability and symptom control while on Invega Sustenna®:

5. State the reason or medical necessity for switching to Invega Trinza™ (if a renewal request, proceed to question #6).

6. Is the beneficiary receiving an oral antipsychotic as concurrent therapy with Invega Sustenna® or with Invega Trinza™? ☐ Yes ☐ No
7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:

Drug Name	Dose	Frequency

8. If "YES" to question #6, why is the oral antipsychotic being prescribed?

9. If this is a renewal request, please provide most recent Invega Trinza™ administration information below:

Last Administration Dates	Dose	Name Of Person Administering Injection:	Facility Name Where Injection Administered:

10. Is the beneficiary living in a residential treatment facility? If "YES", give name and location of facility: ☐ Yes ☐ No

11. If "YES" to question #10, what is estimated date of discharge? _____

12. How will the beneficiary be monitored to ensure compliance with the 3-month shots?

13. State the name of the pharmacy that will be dispensing the Invega Trinza™ for this beneficiary:

14. Explain how the pharmacy will supply the Invega Trinza™ for this beneficiary (e.g., dispense to the beneficiary or ship to prescriber's office/facility):

15. What is the scheduled appointment date and time to administer the Invega Trinza™ from this PA request, if approved?

16. What is the plan for scheduling the next appointment date(s) for future injections?

17. Invega Trinza™ strength requested: (Drug is subject to quantity limits) _____

_____ _____

Prescriber Signature (Required) ***Date***

Prescriber's original signature required; copied, stamped, or e-signature are not allowed.

This signature certifies that the information provided in the Statement of Medical Necessity is accurate and substantiated by the patient's medical records. The prescriber also agrees that Medicaid may audit this patient's medical records to ascertain the medical necessity for accuracy of data submitted.