Magellan HEALTHCARE SM

Invega Trinza Injection Request Form
Fax to Magellan: 1.888.656.4916

(All requests must be approved in advance to ensure authorization)

Today's Date: _____

Member Name: _____ Medicaid ID #: _____

Provider: _____ Contact: _____

Contact Phone Number: _____ Provider MIS #: _____

Service Location: _____

Current Diagnosis: ☐ Schizophrenia ☐ Other (please explain:

_____

_____

Is the member over age 18? ☐ Yes ☐ No Is the member over age 65? ☐ Yes ☐ No

Dementia related psychosis? ☐ Yes ☐ No

Is the member a female of child bearing age? ☐ Yes ☐ No

If yes, most recent pregnancy test Date: _____ Result: _____

What is the plan for pregnancy prevention while member is being treated with Invega trinza?

_____

Is there a history of:

Diabetes	☐ Yes ☐ No	Hypertension	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	NMS	☐ Yes ☐ No
Seizures	☐ Yes ☐ No	Syncope	☐ Yes ☐ No
Vertigo	☐ Yes ☐ No	Low WBC	☐ Yes ☐ No

Please explain any "Yes" answer above. Please include relevant dates: _____

_____

_____

_____

_____

What are the member's specific symptoms that are being targeted with this treatment? _____

Member has had 4 or more months of treatment with Invega sustenna	☐ Yes ☐ No	Dates:
All Medical Necessity Criteria for treatment with Invega sustenna was met	☐ Yes ☐ No	
Member's symptoms have greatly improved while on Invega sustenna	☐ Yes ☐ No	
Member has not had any side effects from invega sustenna	☐ Yes ☐ No	
Member has remained in the community while on Invega sustenna	☐ Yes ☐ No	

There is clear documentation that the individual has been prescribed several oral antipsychotic medications, but could not be safely and effectively treated with any of those medications. Trials should include oral Risperdal (including Risperdal M-Tabs), or oral Invega. There is documentation that other long acting injectables have been tried and were not successful. Please document why the member cannot be treated with Haldol or Prolixin decanoate or Risperdal consta. Documentation should include the dose(s) of these oral and injectable medications, the start and end dates they were prescribed, and the reason why Invega trinza is expected to be effective, even though oral Risperdal, oral Invega or other oral or injectable antipsychotics were not. _____

Please explain the medical necessity of Invega trinza over the continued use Invega sustenna or other long acting injectable/oral antipsychotic. Please note that convenience to the member or provider is not a medically necessary reason.

Please list all current medications and doses:

Medication:	Dosage:

If member is currently on oral medications, please address how the member is able to comply with these oral medications but not be able to take oral antipsychotics.

Dates of most recent:

EKG:		Electrolyte panel:	
Serum magnesium:		Renal panel:	
Liver panel:		CBC:	
AIMS rating:			

Please note any abnormal findings.

Please note the plan in place for monthly weight and blood pressure checks. _____

Please note the plan for timely monitoring of side effects and/pr reemergence of symptoms. _____

Please note the plan and frequency for monitoring electrolytes, blood glucose, lipids and cholesterol, prolactin levels, CBC, and EPS/TD/NMS with regular AIMS. _____

The member has agreed to receive the injections on a regular basis, at the interval prescribed, and a person or agency that is geographically accessible and capable of dispensing and monitoring the injections at the required frequency has been identified.

☐ Yes ☐ No

There is not more than one provider prescribing antipsychotic medication to this client.

☐ Yes ☐ No

The maximum FDA approved dosage is 819 mg IM every 3 months. Amounts in excess of this dose and frequency have not been shown to have additional efficacy, so will not be authorized.

Initial authorization for Invega trinza will be for 6 months (2 injections). Subsequent prior authorization frequency may be determined, and will be contingent upon evidence of clinical efficacy and appropriate clinical monitoring.

Dosage Information for authorization:

Please authorize for: _____ months or _____ injections

Dosage given on each appointment date: _____ (mg)

Dates of injections: _____ _____

_____ _____ _____

J2426-TH (Invega trinza) x _____ Units (1 mg = 1 unit)

96372 (injection) x _____ (number of injections)

_____

Requesting MD/APRN name (print) signature date