Magellan HEALTHCARE SM

Invega Sustenna Injection Request Form
Fax to Magellan: 1.888.656.4916

(All requests must be approved in advance to insure 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

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

_____

_____

_____

The client's ability to tolerate extended exposure to Risperdal or Invega has been established by the use of oral Risperdal (including M-Tabs), oral Invega, or Risperdal Consta prior to the patient receiving Invega Sustenna. Please list the names of medications that establish this exposure, doses and dates of treatment:

_____

_____

_____

There is clear documentation that the client cannot take oral Risperdal (including M-tabs), oral Invega, or Risperdal Consta. Include patient-specific reasons why Invega Sustenna is expected to be effective even when these other medications were not:

_____

_____

There is clear documentation that the client cannot be treated with Haldol Decanoate or Prolixin Decanoate:

_____

_____

There is clear documentation that the client has been prescribed several oral antipsychotic medications, but could not be safely and effectively treated with any of those medications. ☐ Yes ☐ No (explain below)

_____

_____

_____

The client 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 the injections at the required frequency has been identified. ☐Yes ☐No

There is not more than one provider prescribing antipsychotic medications to this client. ☐ Yes ☐ No

Recent laboratory tests (CBC, lipid panel, FBS) have been completed and reviewed:
☐ Yes Date reviewed: _____ ☐ No

Results: _____

_____

The maximum FDA approved dosage is 234 mg each month. Amounts in excess of this dose and frequency have not been shown to have additional efficacy, so will not be authorized.

Please list all current medications and doses:

Medication:	**Dosage:**

Initial Prior Authorization for Invega Sustenna will be for 6 months. 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 (Invega) x _____ Units (1 mg = 1 unit)
96372 (injection) x _____ (number of injections)