



**Statement of Medical Necessity Information Form for Invega Trinza™**

Fax the completed form requesting Invega Trinza™ and chart notes to 1-866-546-0484 for review.

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.*