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

Fax the completed form requesting Invega Trinza™ and chart notes to Empower Healthcare Solutions 1-866-546-0484 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.

MEDICAID ID NUMBER:  DATE OF BIRTH:  Prescriber Information  LAST NAME:  SPI NUMBER:  PHONE NUMBER:  If this is initial request for Invega Trinza™, how long has the beneficiary received Invega Sustenna®:  List Last 4 Administration Dates Of Invega Sustenna®:  List Last 4 Administration Dates Of Invega Sustenna®:  List Last 4 Administration Dates Of Invega Sustenna®:  1)  2)  3)  4)  3. What is the diagnosis being treated?  4. Explain stability and symptom control while on Invega Sustenna®:	Beneficiary Information									
PRESCRIBER Information  LAST NAME:  NPI NUMBER:  PHONE NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  Lift his is initial request for Invega Trinza™, how long has the beneficiary received Invega Sustenna®:  List Last 4 Administration Dates Of Invega Name Of Person(s) Administering Injection(s):  List Last 4 Administration Dates of Invega Sustenna®:  List Last 4 Administration Dates of Invega Name Of Person(s) Administering Injection(s):  Explain stability and symptom control while on Invega Sustenna®:  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™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:	LAST NAME:	FIRST NAME:								
PRESCRIBER Information  LAST NAME:  NPI NUMBER:  PHONE NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  Lift his is initial request for Invega Trinza™, how long has the beneficiary received Invega Sustenna®:  List Last 4 Administration Dates Of Invega Name Of Person(s) Administering Injection(s):  List Last 4 Administration Dates of Invega Sustenna®:  List Last 4 Administration Dates of Invega Name Of Person(s) Administering Injection(s):  Explain stability and symptom control while on Invega Sustenna®:  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™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:										
PRESCRIBER Information  LAST NAME:  NPI NUMBER:  PHONE NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  Lift his is initial request for Invega Trinza™, how long has the beneficiary received Invega Sustenna®:  List Last 4 Administration Dates Of Invega Name Of Person(s) Administering Injection(s):  List Last 4 Administration Dates of Invega Sustenna®:  List Last 4 Administration Dates of Invega Name Of Person(s) Administering Injection(s):  Explain stability and symptom control while on Invega Sustenna®:  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™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:	MEDICAID ID NUMBER:  DATE OF BIRTH:									
AST NAME:    FIRST NAME:				_	-					
DEA NUMBER:  DEA NUMBER:  DEA NUMBER:  FAX NUMBER:  FAX NUMBER:  FAX NUMBER:  If this is initial request for Invega Trinza™, how long has the beneficiary received Invega Sustenna®:  List Last 4 Administration Dates Of Invega Sustenna®:  Name Of Person(s) Administering Injection(s):  Sustenna®:  Explain stability and symptom control while on Invega Sustenna®:  Explain stability and symptom control while on Invega Sustenna®:  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™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:	Prescriber Information									
PHONE NUMBER:  FAX 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®:  1)   Facility Name Where Injection Administered:  Sustenna®:  1)   Facility Name Where Injection Administered:  2)   Facility Name Where Injection Administered:  3)   Facility Name Where Injection Administered:  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).	NPI NUMBER:		DEA NUMBEI	R:						
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®:  1.   Facility Name Where Injection Administered: Sustenna®:  1.   Facility Name Where Injection Administered: Sustenna®:  2.   Provide the following information regarding the last 4 administration dates of Invega Sustenna®:  Facility Name Where Injection Administered: Sustenna®:  2.   Facility Name Where Injection Administered: Sustenna®:  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										
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:  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™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:	PHONE NUMBER:		FAX NUMBER	₹:						
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:  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™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:	_									
2. Provide the following information regarding the last 4 administration dates of Invega Sustenna®:  List Last 4 Administration Dates Of Invega Sustenna®:    1	Clinical Criteria Documentation	****Do <b>not</b> include docum	nentation that	is not reque	sted on this	form****				
2. Provide the following information regarding the last 4 administration dates of Invega Sustenna®:  List Last 4 Administration Dates Of Invega Sustenna®:    1	<ol> <li>If this is initial request for Invega Trinza<sup>π</sup></li> </ol>	 M, how long has the b∈	eneficiary rec	eived Inv	ega Susten	na®:				
Sustenna®:  1)										
1)   2)   3   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™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:	List Last 4 Administration Dates Of Invega	Name Of Person(s) Adm	ninistering Inj	ection(s):	Facility Na	me Where	Injection A	Administe	ered:	
2) 3) 4) 4) 4) 4) 4. Sharp 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 Sustenna™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:										
3)										
4) 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										
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 ☐ Yes ☐ No Trinza™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:										
<ul> <li>4. Explain stability and symptom control while on Invega Sustenna®:</li> <li>5. State the reason or medical necessity for switching to Invega Trinza™ (if a renewal request, proceed to question #6).</li> <li>6. Is the beneficiary receiving an oral antipsychotic as concurrent therapy with Invega Sustenna® or with Invega Trinza™?</li> <li>7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:</li> </ul>	[4]									
<ul> <li>4. Explain stability and symptom control while on Invega Sustenna®:</li> <li>5. State the reason or medical necessity for switching to Invega Trinza™ (if a renewal request, proceed to question #6).</li> <li>6. Is the beneficiary receiving an oral antipsychotic as concurrent therapy with Invega Sustenna® or with Invega Trinza™?</li> <li>7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:</li> </ul>	3. What is the diagnosis being treated?									
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 ☐ Yes ☐ No  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:		hile on Invega Sustenr	na®•							
6. Is the beneficiary receiving an oral antipsychotic as concurrent therapy with Invega Sustenna® or with Invega Trinza™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:	4. Explain stability and symptom control wi	ille on ilivega susteill	ia .							
6. Is the beneficiary receiving an oral antipsychotic as concurrent therapy with Invega Sustenna® or with Invega Trinza™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:										
Trinza™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:	5. State the reason or medical necessity for switching to Invega Trinza™ (if a renewal request, proceed to question #6).									
Trinza™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:										
Trinza™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:										
Trinza™?  7. If YES to question #6, state the drug name, dose, and frequency of the oral dose:	6. Is the beneficiary receiving an oral antip	sychotic as concurrent	t therapy wit	h Invega S	Sustenna®	or with Inv	⁄ega ┌	1 <sub>V</sub> [	7 N	
	Trinza™?						L	ıres ∟	INO	
Drug Name Dose Frequency	7. If YES to question #6, state the drug nam	ne, dose, and frequenc	cy of the oral	dose:						
	Drug Name	Do	se			Free	quency			
								· ·		
8. If "YES" to question #6, why is the oral antipsychotic being prescribed?	8. If "YES" to question #6, why is the oral a	ntipsychotic being pre	escribed?							

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

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

Last Administration Dates	Dose	Name Of Person Administering Injection:	Facility Name Where Injection Administered
LO. Is the beneficiary living i	n a residential tr	reatment facility? If "YES", give name and locat	ion of facility: Yes No
11. If "YES" to question #1	0, what is estim	nated date of discharge?	
12. How will the beneficiar	ry be monitored	to ensure compliance with the 3-month sho	ots?
13. State the name of the	pharmacy that	will be dispensing the Invega Trinza™ for this	s beneficiary:
14. Explain how the pharm prescriber's office/facil		the Invega Trinza™ for this beneficiary (e.g.,	dispense to the beneficiary or ship to
	appointment d	ate and time to administer the Invega Trinza	™ from this PA request, if approved?
16. What is the plan for sc	heduling the ne	ext appointment date(s) for future injections	?
 17. Invega Trinza™ strengt	:h requested: (D	Orug is subject to quantity limits)	

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.