STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR MEDICAL SERVICES

Office of Pharmacy Service
Prior Authorization Criteria

INVEGA TRINZA™
(paliperidone palmitate)

Prior Authorization Request Form

Invega Trinza™, a 3-month injection, is an atypical antipsychotic indicated for the treatment of schizophrenia in patients after they have been adequately treated with Invega Sustenna® (1-month paliperidone palmitate extended-release injectable suspension) for at least four months.

Prior authorization requests for Invega Trinza™ will be approved if the following criteria are met:

1) Patient must be eighteen (18) years of age or older; **AND**
2) Patient must have a diagnosis of schizophrenia; **AND**
3) Invega Trinza is to be used only after Invega Sustenna (1-month paliperidone palmitate extended-release injectable suspension) has been established as adequate treatment for at least four months; **AND**
4) The last two doses of Invega Sustenna should be the same dosage strength before starting Invega Trinza.

References

1) Invega Trinza™ package insert 5/2015
2) Lexi-Comp Clinical Application 9/21/2015

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Approved by the DUR Board 09-23-2015