Prior Authorization Approval Criteria

Invega (paliperidone)

Generic name: paliperidone

Brand name: Invega

Medication class: atypical antipsychotics

FDA-approved uses: Treatment of schizophrenia
Treatment of schizoaffective disorder

Criteria for use for patients with recent psychiatric hospitalization (within the last three months):

- Prescriber states that patient is currently stable on the requested medication

Criteria for use for Schizophrenia: (bullet points below are all inclusive unless otherwise noted)

- Clinically diagnosed schizophrenia
- Patient must be 12 years and older
- Failure, intolerance or had a contraindication to at least two formulary atypical antipsychotic agents such as olanzapine, quetiapine, risperidone, clozapine or ziprasidone

Criteria for use for Schizoaffective disorder: (bullet points below are all inclusive unless otherwise noted)

- Clinically diagnosed schizoaffective disorder
- Patient must be 18 years and older
- Failure, intolerance, or had a contraindication to at least two formulary atypical antipsychotic agents such as olanzapine, quetiapine, risperidone, or ziprasidone

Criteria for continuation of therapy:

- Patient's therapy has been re-evaluated within the last 12 months, unless a re-evaluation is not clinically appropriate for the patient's condition at this time.
- Patient is tolerating treatment and there continues to be a medical need for the medication
- Patient has disease stabilization or improvement in disease (as defined by standard parameters for the patient's condition)

Approval Duration:

- Initial 1 year
- Renewal 1 year

Pharmacy Benefit:

- Pharmacy

Reviewed: 6/14/2017 – updated criteria for use & contraindications, added continuation of therapy criteria, approval duration & benefit type