Medication Prior Authorization Form
Invega Sustenna (Paliperidone)

STEP 1: Clearly Print and Complete to Expedite Processing	
Date:	**Prescriber First & Last Name:**
Patient Last Name:	**Prescriber NPI:**
Patient First Name:	**Prescriber Specialty:**
Patient ID:	**Prescriber Phone:**
Patient Birth Date:	**Prescriber Fax:**
Patient Gender: **Male** **Female**	**Contact Person:**

STEP 2: Medication History

Invega Sustenna

Diagnosis:

- ☐ **Schizophrenia**
- ☐ **Other:**____

Patient has tried oral risperidone or Invega:

- ❑ Yes
- ❑ No

Reason for prescribing Invega Sustenna:

- ❑Nonadherence to oral antipsychotics
- ❑Other:____

Prescriber is a psychiatrist:

- ❑ Yes
- ❑ No

All criteria is required for authorization.

STEP 3: Complete and Fax To: Colorado Access Prior Authorization @ **720-744-5127**
Prescriber Signature:
For Questions: Colorado Access Customer Care at 303-751-9005 or 800-511-5010 M-F 8am-6pm
If Patient Meets Criteria- Allow up to 3 Business Days for Processing
If Criteria Not Met- Submit chart documentation with form citing complex medical circumstances
If Approved, Coverage Allowed For: up to12 months, subject to formulary changes

Formularies are available on our website at: HTTP://WWW.ACCESSADVANTAGE.COACCESS.COM/DRUG-LIST