Montana Healthcare Programs
Drug Prior Authorization Coverage Criteria

Invega Trinza™ (paliperidone)

Review Criteria

Member must meet all the following criteria:

- Subject to Preferred Drug List requirements
- Member must be at least 18 years of age
- Member must have diagnosis of schizophrenia
- Member must have clinical rationale that oral therapy cannot be used
- Tolerability with corresponding oral molecule must be established prior requesting approval for injectable therapy
- Member must have been treated with Invega Sustenna for at least four consecutive months
- Approval granted in one-year intervals

Limitations:

- One injection every 84 days