



Montana Healthcare Programs Drug Prior Authorization Coverage Criteria

Invega Hafyera™ (paliperidone palmitate)

Review Criteria

Member must meet all the following criteria:

Initial Coverage Criteria

- Subject to Preferred Drug List requirements
- Member must be at least 18 years of age
- Member must have diagnosis of Schizophrenia
- Must be prescribed by or in consult with a psychiatric specialist
- Member must have clinical rationale that oral therapy cannot be used
- Tolerability with corresponding oral molecule must be established prior to requesting approval for injectable therapy
- Member must have been treated with Invega Sustenna™ for at least four consecutive months or Invega Trinza™ for one three-month injection cycle
- Initial coverage authorization will be granted for one year
- Maximum dose is one injection every six months
 - New start dosing guidelines:
 - 156mg once a month paliperidone = 1,092mg every 6 months paliperidone
 - 234mg once a month paliperidone = 1,560mg every 6 months paliperidone
 - **No equivalent doses of 39mg, 78mg or 117mg once a month dosing
 - 546mg every three months paliperidone = 1,092mg every 6 months paliperidone
 - 819mg every three months paliperidone = 1,560mg every 6 months paliperidone
 - **No equivalent doses for 273mg or 410mg every three months dosing

Renewal Coverage Criteria:

- Member has been adherent to Invega Hafyera™
- Member has experienced a positive clinical response (stabilization or decrease in schizophrenia symptoms)
- Annual specialist consult required if prescriber is not a specialist
- Renewal coverage authorization will be granted for one year
- Maximum dose is one injection every six months