

Must meet all of the criteria listed below:

- Must have a diagnosis of schizophrenia or schizoaffective disorder
- Must have an adequate trial and failure or an inadequate response, duration of at least 4 weeks, or intolerance to two generic atypical antipsychotics (e.g., aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone)

Limitations:

Length of Authorization (if above criteria met)	
Initial Authorization	Up to duration of member's membership with plan
Quantity Level Limit	
Invega 1.5mg, 3mg, and 9mg	1 tablet per day
Invega 6mg	2 tablets per day

If the established criteria are not met, the request is referred to a Medical Director for review.

REFERENCES

1. Invega [package insert]. Titusville, NJ: Janssen LP; January 2007.

RECORD RETENTION

Records Retention for Evolent Health documents, regardless of medium, are provided within the Evolent Health records retention policy and as indicated in CORP.028.E Records Retention Policy and Procedure.

REVIEW HISTORY

DESCRIPTION OF REVIEW / REVISION	DATE APPROVED
<i>Annual Review</i>	<i>02/17, 02/18</i>

