

# OPTIMA HEALTH PLAN

## PHARMACY STEP-THERAPY REQUEST FORM\*

**Directions:** *The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff and faxed to 757-552-7516 or 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct.*

**Drug Name: Invega™ (paliperidone)**

- Invega™ is indicated for the acute and maintenance treatment of schizophrenia.
- The once-daily oral medication is specifically designed to deliver paliperidone -- the active metabolite derived from risperidone -- through the OROS(R) extended-release technology.
- Invega is contraindicated in patients with known hypersensitivity to paliperidone, risperidone, or any component of the formulation.
- Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo.

**Please indicate below reason for request:**

Patient is intolerant to risperidone

**OR**

Patient had an inadequate response to risperidone

**AND**

Patient has tried and failed another atypical antipsychotic. Please list the agent(s):

\_\_\_\_\_

**Patient:** \_\_\_\_\_

**Member Number:** \_\_\_\_\_

**SIGNED** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Physician Name** \_\_\_\_\_ **Phone Number** \_\_\_\_\_

**Fax Number** \_\_\_\_\_

**Pharmacy Name** \_\_\_\_\_ **Pharmacy Tel #** \_\_\_\_\_

**(IF AVAILABLE)**

\* Approved by the Pharmacy and Therapeutics Committee on 5/17/2007