Clinical Policy: paliperidone ER (Invega®)

Reference Number: NE.PMN.30
Effective Date: 01/01/2017

Description
The intent of the criteria is to ensure that patients follow selection elements established by Centene medical policy for paliperidone ER (Invega®).

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation that paliperidone ER (Invega®) is medically necessary for members meeting the following criteria:

Initial Approval Criteria:

I. Schizoaffective disorder (must meet all)
   A. Diagnosis of schizoaffective disorder;
   B. Age ≥ 18 years;
C. Failure of two formulary generic atypical antipsychotics, each used for ≥ 4 weeks
    OR contraindication to ALL formulary generic antipsychotics FDA approved for
    schizoaffective disorder;
D. Request does not exceed the FDA approved dose limit of 12mg/day.

Approval duration: 12 months

II. Schizophrenia (must meet all)
   A. Diagnosis of schizophrenia;
   B. Age ≥12 years;
   C. Failure of two formulary generic atypical antipsychotics, each used for ≥ 4 weeks
      OR contraindication to ALL formulary generic antipsychotics FDA approved
      schizophrenia;
   D. Request does not exceed the FDA approved dose limit of 12mg/day.

Approval duration: 12 months

Continued Approval (must meet all as applicable):

   A. If request is for a dose increase, member must be adherent to current regimen and request should
      not exceed the FDA approved dose limit 12mg/day

Approval duration: 12 months

Background
Paliperidone is an atypical antipsychotic and is the major active metabolite of risperidone, a
benzisoxazole antipsychotic. Paliperidone has been shown to exhibit central dopamine (D-2) and
serotonin (5HT2A) receptor antagonism. It is FDA approved for treatment of schizoaffective
disorder and schizophrenia.

References (or Bibliography)
   http://www.clinicalpharmacology-ip.com
2. INVEGA® package insert. Titusville, New Jersey:Janssen Pharmaceuticals, Inc.; April

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