sage elevate

INVEGA (Sustenna, Trinza, Hafyera) Orders
(Paliperidone Palmitate)

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PATIENT INFORMATION

Patient Name: _____ **DOB**: _____ **Gender:** ☐ M ☐ F

Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Phone: _____ **Email:** _____ **Ht:** _____ **Wt:** _____

Please Attach: ☐ Insurance information ☐ Most recent labs

☐ **NKDA** ☐ **Allergies:** _____

PRESCRIBER INFORMATION

Ordering Provider Name: _____

Provider NPI: _____ **Phone:** _____ **Fax:** _____

Practice Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

REQUIRED INFORMATION

☐ History and Physical exam notes ☐ Current Medication List

☐ Recent office notes ☐ All tried and failed oral medications: _____

Has the patient's tolerability to oral paliperidone or oral risperidone been established prior to initiating INVEGA SUSTENNA? ☐YES ☐ NO

MEDICATION ORDERS

ICD-10 Diagnosis Codes: ☐F20.9 Schizophrenia, unspecified ☐F25.9 Schizoaffective disorder, unspecified

☐ Other: _____

☐**New to Therapy** ☐ **Continuation of Therapy:** Date of last dose (if applicable): _____

DOSING/FREQUENCY:

Invega Sustenna Loading dose : ☐ 234 mg **(Day 1)** ☐ 156 mg **(Day 8)**

Maintenance dose *(once monthly)* : ☐ 39 mg ☐ 78 mg ☐ 117 mg ☐ 156 mg ☐ 234 mg

Invega Trinza *(every 3 months)* ☐ 273 mg ☐ 410 mg ☐ 546 mg ☐ 819 mg

Invega Hafyera *(every 6 months)* ☐ 1092 mg ☐ 1560 mg

☐ Refills: _____

Sage Elevate Standing Orders:

☑ Provide treatment under Sage Elevate's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name	Provider Signature	Date