[Insert Physician Letterhead]

[Insert Name of Medical Director] RE: Member Name: [Insert Member Name]

[Insert Payer Name] Member Number: [Insert Member Number]

[Insert Address] Group Number: [Insert Group Number]

[Insert City, State ZIP]

**REQUEST:** Authorization for treatment with [INVEGA SUSTENNA® (paliperidone palmitate) / INVEGA TRINZA® (paliperidone palmitate) / INVEGA HAFYERA™ (paliperidone palmitate)]

**DIAGNOSIS:** [Insert Diagnosis] [Insert ICD]

**DOSE AND FREQUENCY:** [Insert Dose & Frequency]

**REQUEST TYPE:** ☐ Standard ☐ EXPEDITED

Dear [Insert Name of Medical Director]:

I am writing to support my request for an **authorization** for the above-mentioned patient to receive treatment with [INVEGA SUSTENNA® (paliperidone palmitate) / INVEGA TRINZA® (paliperidone palmitate) / INVEGA HAFYERA™ (paliperidone palmitate)] for [Insert Indication]. My request is supported by the following:

**Summary of Patient’s Diagnosis**

[Insert patient’s diagnosis, date of diagnosis, lab results and date, current condition]

**Summary of Patient’s History**

[Insert previous therapies/procedures, response to those interventions, description of patient’s recent symptoms/condition, summary of your professional opinion of the patient’s likely prognosis or disease progression without treatment with [INVEGA SUSTENNA® (paliperidone palmitate) / INVEGA TRINZA® (paliperidone palmitate) / INVEGA HAFYERA™ (paliperidone palmitate)]. Note: Exercise your medical judgment and discretion when providing a diagnosis and characterization of the patient’s medical condition.]

**Rationale for Treatment**

[Insert summary statement for rationale for treatment such as: Considering the patient’s history, condition, and the full Prescribing Information supporting uses of [INVEGA SUSTENNA® (paliperidone palmitate) / INVEGA TRINZA® (paliperidone palmitate) / INVEGA HAFYERA™ (paliperidone palmitate)], I believe treatment with [INVEGA SUSTENNA® (paliperidone palmitate) / INVEGA TRINZA® (paliperidone palmitate) / INVEGA HAFYERA™ (paliperidone palmitate)] at this time is medically necessary, and should be a covered and reimbursed service. You may consider including documents that provide additional clinical information to support the recommendation for [INVEGA SUSTENNA® (paliperidone palmitate) / INVEGA TRINZA® (paliperidone palmitate) / INVEGA HAFYERA™ (paliperidone palmitate)] for this patient, such as the full Prescribing Information, peer-reviewed journal articles, or clinical guidelines.]

[Given the urgent nature of this request,] please provide a timely authorization. Contact my office at [Insert Phone Number] if I can provide you with any additional information.

Sincerely,

[Insert Physician Name and Participating Provider Number]

☐ If this request is denied, I am requesting an expedited Exception review by a professional in my specialty.

Enclosures:

[Include full Prescribing Information and the additional support noted above]