Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 11/2021**
Policy Number: PHW.PDL.027	**Effective Date: 01/01/2020** **Revision Date: 10/2021**
Policy Name: Antipsychotics	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ✓ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ✓ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q1 2022: revised according to DHS revisions effective 01/03/2022

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Antipsychotics

Reference Number: PHW.PDL.027
Effective Date: 01/01/2020
Last Review Date: 10/2021

Revision Log

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health and Wellness® that Antipsychotics are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antipsychotics

A. Prescriptions That Require Prior Authorization

Prescriptions for Antipsychotics that meet any of the following conditions must be prior authorized:

1. A non-preferred Antipsychotic. See the Preferred Drug List (PDL) for the list of preferred Antipsychotics at: https://papdl.com/preferred-drug-list.

2. An Antipsychotic with a prescribed quantity that exceeds the quantity limit.

3. An Antipsychotic when prescribed for a child under 18 years of age.

4. An Atypical Antipsychotic when there is a record of a recent paid claim for another Atypical Antipsychotic (therapeutic duplication).

5. A Typical Antipsychotic when there is a record of a recent paid claim for another Typical Antipsychotic (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antipsychotic, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For Invega (paliperidone), **one** of the following:

   a. Has a history of therapeutic failure, contraindication, or intolerance of the preferred Antipsychotics,
   b. Has active liver disease with elevated LFTs or is at risk for active liver disease,
   c. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antipsychotic (does not apply to non-preferred brands when the

therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred);

AND

2. For all other non-preferred Antipsychotics, **one** of the following:

   a. Has a history of therapeutic failure, contraindication, or intolerance (such as, but not limited to, diabetes, obesity, etc.) to the preferred Antipsychotics
   b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antipsychotic (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred);

   AND

3. For an Antipsychotic for a child under the age of 18 years, **all** of the following:

   a. Has severe behavioral problems related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses:

      i. Autism spectrum disorder,
      ii. Intellectual disability,
      iii. Conduct disorder,
      iv. Bipolar disease,
      v. Tic disorder, including Tourette's syndrome,
      vi. Transient encephalopathy,
      vii. Schizophrenia,

   b. **One** of the following:

      i. If less than 14 years of age, is being prescribed the medication by or in consultation with **one** of the following:

         a) Pediatric neurologist,
         b) Child and adolescent psychiatrist,
         c) Child development pediatrician,

      ii. If 14 years of age or older, is being prescribed the medication by or in consultation with **one** of the following:

         a) Pediatric neurologist,
         b) Child and adolescent psychiatrist,
         c) Child development pediatrician,
         d) General psychiatrist,

c. Has chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies such as, but not limited to, evidence-based behavioral, cognitive, and family based therapies,

d. Has documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS);

AND

4. For therapeutic duplication, **one** of the following:

   a. For an atypical Antipsychotic, is being titrated to or tapered from another atypical Antipsychotic,
   b. For a typical Antipsychotic, is being titrated to or tapered from another typical Antipsychotic,
   c. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

   AND

5. If a prescription for an Antipsychotic is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

   NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR PREFERRED and NON-PREFERRED ANTIPSYCHOTICS FOR CHILDREN UNDER 18 YEARS OF AGE: The determination of medical necessity of a request for renewal of a prior authorization for an Antipsychotic for a child under 18 years of age that was previously approved will take into account whether the member:

1. Has **all** of the following:

   a. Documented improvement in target symptoms,
   b. Documented monitoring of weight or BMI quarterly,
   c. Documented monitoring of blood pressure, fasting glucose, fasting lipid panel, and EPS using AIMS after the first 3 months of therapy and then annually,
   d. Documented plan for taper/discontinuation of the Antipsychotic or rationale for continued use.

NOTE: If the member does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Except as noted below, prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antipsychotic. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer (a psychiatrist) for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer (a psychiatrist), the services are medically necessary to meet the medical needs of the member.

All requests for prior authorization of an antipsychotic medication for a child under 18 years of age will be automatically forwarded to a physician reviewer (a psychiatrist) for a medical necessity determination. The physician reviewer (a psychiatrist) will prior authorize the prescription based on **one** of the following:

1. The guidelines in Section B. 3. are met.
2. In the professional judgment of the physician reviewer (a psychiatrist), the services are medically necessary to meet the medical needs of the member.

D. **Dose and Duration of Therapy**

Approvals of requests for prior authorization of prescriptions for an Antipsychotic **for a child under 18 years of age** will be approved as follows:

- Up to 3 months for an initial request.
- Up to 12 months for a renewal of a previously approved request.

Approvals of requests for prior authorization of prescriptions for an Antipsychotic **for an adult 18 years of age or older** will be approved as follows:

- 12 months

E. References

1. Alexander GC, Gallagher SA, Mascola, et al. Increasing off-label use of antipsychotic medication in the United States, 1995-2008, Pharmacoepidemiology and Drug Safety (2011), doi: 10.1002/pds.2082.
2. Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes, Diabetes Care, 27:2, February 2004.

3. McKinney C, Renk K. Atypical antipsychotic medication in the management of disruptive behaviors in children: Safety guidelines and recommendations, Clinical Psychology Review (2010), doi:10.1016/j.cpr.2010.11.005.
4. Olfson M, Blanco C, Linxu L, et al. National Trends in the Outpatient Treatment of Children and Adolescents With Antipsychotic Drugs, Arch Gen Psychiatry. 2006;63:679-685.
5. Pappadopulos E, MacIntyre JC, Crismon ML. Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth (TRAAY). Part II, J Am Acad Child Adolesc Psychiatry, 42:2, February 2003.
6. Schur SB, Sikich L, Rindling RL. Treatment Recommendations for the Use of Antipsychotics for Aggressive Youth (TRAAY). Part I: A Review, J Am Acad Child Adolesc Psychiatry, 42:2, February 2003.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022: revised according to DHS revisions effective 01/03/2022	10/2021