

Clinical Policy: Antipsychotics

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Line of Business: LTSS

[Coding Implications](#)

[Revision Log](#)

Policy/Criteria

** Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria**

It is the policy Pennsylvania Health and Wellness will follow the **medically necessity criteria for children under 18 years of age** established by the Pennsylvania Department of Human Services Medical Assistance Bulletin on Prior Authorization of Antipsychotics – Pharmacy Services. The medical necessity is determined when the following criteria are met:

I. Requirements for Prior Authorization of Antipsychotics

A. Prescriptions requiring prior authorization

1. All non-preferred Antipsychotics.
2. Prescriptions for preferred Antipsychotic with a prescribed quantity that exceeds the quantity limit.
3. A prescription for either a preferred or non-preferred antipsychotic regardless of quantity limit when prescribed for a child under 18 years of age.
4. A prescription for a preferred or non-preferred Atypical Antipsychotic or a preferred or non-preferred Typical Antipsychotic when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs in the point of sale system.
5. A prescription for a preferred or non-preferred oral Atypical Antipsychotic for a recipient 18 years and older when prescribed in a low-dose range as listed in the following table:

Drug	Low Dose Range (mg/day)
Abilify (aripiprazole)	</=10
Clozaril (clozapine)	</=100
Fanapt (iloperidone)	</=2
Fazacllo (clozapine)	</=100
Geodone(ziprasidone)	</=40
Invega (paliperidone)	</=3
Latuda (lurasidone)	</=20
Risperdal (risperidone)	</=1
Rexulti (brexpiprazole)	</=0.5
Saphris (asenapine)	</=5
Seroquel/Seroquel XR (quetiapine)	</=150
Versacloz (clozapine)	</=50
Zyprexa (olanzapine)	</=5

- a. Prior Authorization is not required for the first 60 days of therapy with a prescription for a preferred oral Atypical Antipsychotic when prescribed in a

low-dose range for recipients 18 years of age and older to allow for titration to a therapeutic dose.

6. The plan will grandfather prescriptions for non-preferred antipsychotics for those participants age 18 years and older when the claims history system verifies that the participant has a record of a paid claim for a non-preferred Antipsychotic within the past 90 days from the date of service of the new claim.
 - a. Grandfathering does not apply to:
 - i. Children under 18 years of age
 1. One medical necessity is established, the non-preferred antipsychotic will be authorized if claims history verifies that the participant has a record of a paid claim for the non-preferred medication within the past 90 days.
 - ii. Therapeutic Duplications
 - iii. Lose –dose therapy beyond first 60 days of therapy for participants 18 years of age and older

B. Medical necessity criteria for evaluating prior authorization requests

1. Invega (a or b)
 - a. A history of therapeutic failure of the preferred Antipsychotics
 - b. Active liver disease with elevated LFTs or is at risk for active liver disease
2. For all other non-preferred Antipsychotics
 - a. Has a history of therapeutic failure, contraindication or intolerance (such as, but not limited to, diabetes, obesity, etc.) to the preferred Antipsychotics OR
 - b. For Zyprexa Relprevv (i and ii)
 - i. Is being transitioned from oral olanzapine to Zyprexa Relprevv
 - ii. Has a history of non-compliance with Oral Antipsychotics resulting in decompensation or is at high risk of decompensation
 - b. For aripiprazole Extended-release injectable suspension, for intramuscular use(i. and either ii or iii)
 - i. Is being transitioned from Oral aripiprazole
 - ii. Has a history of non-compliance with oral antipsychotics resulting in decompensation or is at high risk of decompensation
 - iii. Has a current history (within the past 90 days) of being prescribed the same non-preferred antipsychotic
3. For a preferred or non-preferred Antipsychotic for a child under the age of 18 years
 - a. All requests will be done by a physician reviewer (a psychiatrist)
 - b. Has a severe behavioral problem related to psychotic or neuro-developmental disorder such as seen in, but not limited to, the following diagnosis:
 - i. Autism Spectrum Disorder OR
 - ii. Intellectual disability OR
 - iii. Conduct Disorder OR
 - iv. Bipolar disease OR
 - v. TIC Disorder, including Tourette’s Syndrome OR
 - vi. Transient encephalopathy OR
 - vii. Schizophrenia
 - b. If less than 14 years of age, is being prescribed the medication by, or in consultation with a :

- i. Pediatric Neurologist OR
 - ii. Child and Adolescent Psychiatrist OR
 - iii. Child Development Pediatrician
 - c. If 14 years of age or older, is being prescribed the medication by, or in consultation with a:
 - i. Pediatric Neurologist OR
 - ii. Child and Adolescent Psychiatrist OR
 - iii. Child Development Pediatrician OR
 - iv. General Psychiatrist
 - d. Has a 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.
 - e. 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)
4. For therapeutic duplication of an Atypical or Typical Antipsychotic, whether:
 - a. The participant is being titrated to, or tapered from, a drug in the same class OR
 - b. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested
5. For a low dose oral Atypical Antipsychotic for a recipient 18 years of age and older, whether the participant has a diagnosis that is:
 - a. Indicated in the package insert OR
 - b. Listed in nationally recognized compendia for the determination of medically-accepted indications for off-label uses
6. For a preferred low dose oral Atypical Antipsychotic for a recipient 18 years of age and older, for beyond the first 60 days will be allowed automatically if the system can verify a paid claim in the previous 90 days with the following diagnoses:
 - a. Schizophrenia
 - b. Bipolar disorder
 - c. Schizoaffective disorder
 - d. Autism
 - e. Major depression with psychotic features
7. In addition, if a prescription for either a preferred or non-preferred Antipsychotic is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account any quantity limit guidelines.
8. If none of the above criteria are 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 participant.

Approval duration:

Children under 18 years of age - 3 months

Adults – 12 months

II. Continued Therapy

A. For children under 18 years of age:

1. Has documented improvement in target symptoms AND
2. Has documented monitoring of weight or BMI quarterly AND
3. Has documented monitoring of blood pressure, fasting glucose, fasting lipid panel, and EPS using AIMS after the first 3 months of therapy, and then annually AND
4. Has a documented plan for taper/discontinuation of the Antipsychotic or rationale for continued use OR
5. If none of the above criteria are 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 participant.

Approval duration: 12 months

IV. Appendices/General Information

Appendix A: Abbreviation Key

- MME: morphine milligram equivalents
 NSAID: non-steroidal anti-inflammatory drug
 PDL: Preferred drug list
 PDMP: Prescription Drug Monitoring Program

V. Dosage and Administration

There are numerous narcotic analgesics, please refer to the package insert of your drug of interest for information on appropriate dosage and administration.

VI. Product Availability

There are numerous narcotic analgesics, please refer to the package insert of your drug of interest for product availability information.

VII. References

1. Pennsylvania Medical Assistance Bulletin – Prior Authorization of Antipsychotics– Pharmacy Services dated January 6, 2016.

Reviews, Revisions, and Approvals	Date	Approval Date

CLINICAL POLICY
Antipsychotics



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