### Antipsychotic Medications Age and Step Therapy

<table>
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<th>Override(s)</th>
<th>Approval Duration</th>
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<td>Prior Authorization</td>
<td>1 year</td>
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<td>Quantity Limit</td>
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CRX-ALL-0123-18

**Market Applicability**

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**Seroquel XR** (quetiapine XR) tablets | Non-Preferred

**Symbyax** (olanzapine and fluoxetine) | Non-Preferred

**Versacloz** (clozapine) oral suspension | Non-Preferred

**Vraylar** (cariprazine) | Non-Preferred

**MSB Zyprexa tablets**

- Olanzapine tablets | Use MSB criteria
- MSB Zyprexa Zydis oral disintegrating tablets | Preferred
- Olanzapine oral disintegrating tablets | Non-Preferred

**Traditional Antipsychotics**

**Notes**

**MSB Orap** tablets

- Use MSB Criteria
- Preferred

**Pimozide tablets** | Non-Preferred

**perphenazine tablets** | Preferred

**Stelazine** (trifluoperazine) tablets | Preferred

**Navane** (thiothixene) capsules | Preferred

**Loxapine capsules** | Preferred

**Adasuve** inhalation powder | Non-Preferred (Subject to Age Edit Only)

**Prolixin/Permitil** (fluphenazine hydrochloride) tablets, elixir, liquid concentrate | Preferred

**Fluphenazine decanoate injection** | Preferred

**MSB Haldol injection**

- Haloperidol tablets, liquid concentrate, injection | Use MSB criteria
- Preferred

**Thorazine** (chlorpromazine) tablets (excludes injectables) | Preferred

**APPROVAL CRITERIA**

**MULTI-SOURCE BRAND**

Requests for the following antipsychotic medications:

- MSB Abilify
- MSB Clozaril
- MSB Geodon capsules
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- MSB Invega tablets
- MSB Orap tablets
- MSB Risperdal tablets, oral solution
- MSB Risperdal M-tabs oral disintegrating tablets
- MSB Seroquel tablets
- MSB Zyprexa tablets
- MSB Zyprexa Zydis oral disintegrating tablets
- MSB Haldol injection

may be approved when Multi-Source Brand criteria (see specific Multi-Source Brand criteria) AND age limits listed below, are met.

### STEP THERAPY APPROVAL CRITERIA

Requests for the following non-preferred oral atypical antipsychotics medications:

- aripiprazole ODT/solution
- risperidone ODT
- risperidone oral syringe
- Abilify Mycite (aripiprazole with sensor)
- Fanapt (iloperidone)
- Latuda (lurasidone)
- Saphris (asenapine)
- Seroquel XR (brand and generic)
- Symbyax (brand and generic)
- Vraylar (cariprazine)

may be approved when the following criteria AND age limits listed below, are met:

I. Individual has been maintained on a stable dose of the requested medication;

OR

II. Individual has had a trial of and inadequate response or intolerance to one preferred generic oral atypical antipsychotic;
Preferred generic oral atypical antipsychotics: aripiprazole tablet, olanzapine, paliperidone, quetiapine, risperidone tablet/solution, ziprasidone

OR

III. The preferred generics are not FDA approved and do not have an accepted off-label use per the off-label policy for the prescribed indication and the non-preferred agent does;

OR

IV. The request is for quetiapine ER and I. or II. or III above are met; OR

a. Individual has a diagnosis of Major Depressive Disorder; AND

b. Individual must use concomitant antidepressant therapy;

OR

V. The request is for Latuda and I. or II. or III above are met; OR

a. Individual has a diagnosis of bipolar depression; AND

b. Individual has significant cardiovascular risk factors (such as high risk for QTc prolongation);

OR

c. Individual is at high risk for complications related to weight gain.

PRIOR AUTHORIZATION - AGE APPROVAL CRITERIA

Requests for antipsychotic agents in the pediatric population (age 17 and under) may be approved when the following criteria are met:

I. Individual has been maintained on a stable dose of the requested medication;

OR

II. Prescriber is a Psychiatrist, Neurologist or Developmental/Behavioral Pediatrician; OR

III. Prescriber has consulted with a Psychiatrist, Neurologist or Developmental/Behavioral Pediatrician;

OR

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IV. Prescriber does not have timely access to a Psychiatrist, Neurologist of Developmental/Behavioral Pediatrician; **AND**

V. The individual meets the following criteria (Note: If all other conditions below are met, allow 3 month supply to provide time to consult with a specialist):

a. Individual is 5 years of age or older; **AND**

b. Medication being requested is Risperdal (risperidone) tablets or solution; **OR**

c. Individual is 6 years of age or older; **AND**

d. Medication being requested is one of the following:
   i. Abilify (aripiprazole) oral – not Abilify Mycite formulation; **OR**
   ii. Trifluoperazine; **OR**

**OR**

e. Individual is 10 years of age or older; **AND**

f. Medication being requested is one of the following:
   i. Symbyax (olanzapine and fluoxetine); **OR**
   ii. Seroquel (quetiapine); **OR**
   iii. Seroquel XR (quetiapine XR); **OR**
   iv. Saphris (asenapine); **OR**

**OR**

g. Individual is 12 years of age or older; **AND**

h. Medication being requested is one of the following:
   i. Invega (paliperidone) oral; **OR**
   ii. Orap (pimozide); **OR**
   iii. Perphenazine; **OR**
   iv. Thiothixene; **OR**
   v. Fluphenazine decanoate injection; **OR**

**OR**

i. Individual is 13 years of age or older; **AND**

j. Medication being requested is one of the following:
   i. Zyprexa (olanzapine) oral; **OR**
   ii. Latuda (lurasidone); **AND**

VI. Individual has a psychiatric diagnosis that is amenable to treatment with an antipsychotic agent, including, but not limited to the following:

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| Applicable | X | X | NA | NA | X | NA | X | X | NA | X | X | X | NA | NA | NA |

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a. Schizophrenia; OR
b. Bipolar disorder [Seroquel (quetiapine), Risperdal (risperidone), Zyprexa (olanzapine), Geodon (ziprasidone), Seroquel XR (quetiapine), Abilify (aripiprazole), Saphris (asenapine), Latuda (lurasidone), Vraylar (cariprazine), chlorpromazine]; OR
c. Irritability associated with autism [Risperdal (risperidone), Abilify (aripiprazole) – not Abilify Mycite formulation]; OR
d. Severe behavioral problems including explosive hyperexcitability which cannot be accounted for by immediate provocation (chlorpromazine, haloperidol);

**AND**

VII. One of the following:
a. Individual has utilized non-drug treatment measures, such as psychosocial intervention/care, in the previous 12 months; OR
b. Individual has had an acute inpatient visit for a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder in the previous 12 months; OR
c. Individual has had at least 2 visits in outpatient, intensive outpatient, or partial hospitalization setting for a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder in the previous 12 months;

**AND**

VIII. Prescriber is regularly monitoring for metabolic side effects (such as, obtaining blood glucose or Hemoglobin A1C (HbA1c), total cholesterol or LDL-C, reviewing BMI changes);

**AND**

IX. Prescriber is regularly monitoring for neurological side effects [such as, evaluation of movement disorders using tools including Abnormal Involuntary Movement Scale (AIMS) and the Neurological Rating Scale (NRS)];

**OR**

X. Individual is requesting an antipsychotic agent to treat the following diagnoses:
a. Nausea and vomiting (chlorpromazine, perphenazine, prochlorperazine); OR
b. Tourette’s Disorder/tic disorder [Orap (pimozide), Abilify (aripiprazole) – not Abilify Mycite formulation, haloperidol]; OR
c. Pre-surgical apprehension (chlorpromazine);

**AND**

XI. No therapeutic alternative exists or therapeutic alternatives were ineffective.
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**Market Applicability**

- Drug. Service authorization does not guarantee payment for the drug; payment is contingent upon passing all edits contained within the claims payment process, the individual’s continued Medicaid eligibility, the provider’s continued Medicaid eligibility, and the ongoing medical necessity for the drug.

- **SA criteria document:**

  In addition, use of preferred atypical antipsychotic agents prior to a non-preferred atypical antipsychotic will still be required.

  The preferred oral atypical antipsychotic agents are as follows: risperidone, olanzapine, quetiapine fumarate, ziprasidone, aripiprazole tablets, paliperidone. Trial and failure of one of these products is required prior to use of a non-preferred atypical antipsychotic unless the following applies:

  I. Latuda is requested and individual is diagnosed with bipolar disorder along with significant cardiovascular risk factors (such as a high risk of QTc prolongation) or is at high risk for complications related to weight gain.

  **Requests for individuals 18 and over will follow criteria outlined below:**

  All antipsychotic agents are approved for use in individuals 18 and older. However, use of preferred atypical antipsychotic agents prior to a non-preferred atypical antipsychotic will still be required. The preferred oral atypical antipsychotic agents are as follows: risperidone, olanzapine, quetiapine fumarate, ziprasidone, aripiprazole tablets, paliperidone. Trial and failure of one of these products is required prior to use of a non-preferred oral atypical antipsychotic unless the following applies:

  I. Latuda is requested and individual is diagnosed with bipolar disorder along with significant cardiovascular risk factors (such as a high risk of QTc prolongation) or is at high risk for complications related to weight gain.
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| Applicable | X | X | NA | NA | X | X | NA | X | X | X | NA | NA | NA | NA |

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