Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	NA	X	X	X

Antipsychotic Medications Age and Step Therapy

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Atypical Antipsychotics	Comment	Quantity Limit
Abilify Mycite (aripiprazole with sensor) MSB Abilify Aripiprazole tablets Aripiprazole oral disintegrating tablets Aripiprazole solution	Non-Preferred Use MSB criteria Preferred Non-Preferred Non-Preferred	May be subject to quantity limit
clozapine tablets MSB Clozaril	Preferred Use MSB criteria	
Caplyta (lumateperone) capsules	Non-Preferred	
Fanapt (iloperidone) tablets Fanapt (iloperidone) Titration Pack	Non-Preferred	
FazaClo (clozapine) oral disintegrating tablets	Non-Preferred	
MSB Geodon capsules Ziprasidone capsules	Use MSB Criteria Preferred	
MSB Invega tablets Paliperidone ER tablets	Use MSB criteria Preferred	
Latuda (lurasidone) tablets	Non-Preferred	
MSB Risperdal tablets, oral solution MSB Risperdal M-tabs oral disintegrating tablets Risperidone oral tablets Risperidone solution Risperdal oral disintegrating tablets	Use MSB criteria Use MSB criteria Preferred Preferred Non-Preferred	
Saphris (asenapine) sublingual tablets Secuado (asenapine) patch	Non-Preferred Non-Preferred	

Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	NA	X	X	X

MSB Seroquel tablets Quetiapine tablets Seroquel XR (quetiapine XR) tablets	Use MSB criteria Preferred Non-Preferred	
Symbyax (olanzapine and fluoxetine)	Non-Preferred	May be subject to quantity limit (continued)
Versacloz (clozapine) oral suspension	Non-Preferred	
Vraylar (cariprazine)	Non-Preferred	
MSB Zyprexa tablets Olanzapine tablets MSB Zyprexa Zydis oral disintegrating tablets Olanzapine oral disintegrating tablets	Use MSB criteria Preferred Use MSB criteria Non-Preferred	
Traditional Antipsychotics	**Comment**	
MSB Orap tablets Pimozide tablets	Use MSB Criteria Non-Preferred	
perphenazine tablets	Preferred	
Stelazine (trifluoperazine) tablets	Preferred	
Navane (thiothixene) capsules	Preferred	
Loxapine capsules Adasuve inhalation powder	Preferred 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

This policy does not apply to health plans or member categories that do not have pharmacy benefits, nor does it apply to Medicare. Note that market specific restrictions or transition-of-care benefit limitations may apply.

Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	NA	X	X	X

MULTI-SOURCE BRAND

Requests for the following antipsychotic medications:

- MSB Abilify
- MSB Clozaril
- MSB Geodon capsules
- 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 or transdermal atypical* antipsychotics medications:

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

Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	NA	X	X	X

may be approved when the following criteria **AND** age limits/prior authorization 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 is age 10-17 with a diagnosis of bipolar depression; **OR**
- 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;

OR

VI. Secuado patch or Saphris sublingual tablets may be approved if individual is unable to take oral medications;

OR

VII. The requested agent is Abilify Mycite and the prescriber has confirmed clinical necessity to track drug ingestion;

PRIOR AUTHORIZATION - AGE APPROVAL CRITERIA

Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	NA	X	X	X

Initial 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

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 one of the following:

1. Risperdal (risperidone) tablets or solution; **OR**
2. Chlorpromazine; **OR**
3. Prochlorperazine; **OR**
4. Thioridazine; **OR**
5. Haloperidol;

OR

C. Individual is 6 years of age or older;
AND

D. Medication being requested is one of the following:

1. Abilify (aripiprazole) oral – not Abilify Mycite formulation; **OR**
2. Trifluoperazine;

OR

E. Individual is 10 years of age or older;
AND

F. Medication being requested is one of the following:

1. Symbyax (olanzapine and fluoxetine); **OR**
2. Seroquel (quetiapine); **OR**
3. Seroquel XR (quetiapine XR); **OR**
4. Saphris (asenapine); **OR**
5. Latuda (lurasidone)

OR

G. Individual is 12 years of age or older;
AND

Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	NA	X	X	X

H. Medication being requested is one of the following:
    1. Invega (paliperidone) oral; **OR**
    2. Orap (pimozide); **OR**
    3. Perphenazine; **OR**
    4. Thiothixene; **OR**
    5. Fluphenazine decanoate injection; **OR**
    6. Molindone;

OR

I. Individual is 13 years of age or older;
AND
J. Medication being requested is one of the following:
    1. Zyprexa (olanzapine) oral;

AND

VI. Individual has a psychiatric diagnosis that is amenable to treatment with an antipsychotic agent, including, but not limited to the following:
    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 will regularly monitor for metabolic side effects (such as, obtaining blood glucose or Hemoglobin A1C (HbA1c), total cholesterol or LDL-C, reviewing BMI changes);
AND

IX. Prescriber will regularly monitor for neurological side effects [such as, evaluation of

Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	NA	X	X	X

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.

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

I. Criteria above were met at initiation of therapy; **AND**
II. There is confirmation of clinically significant improvement or stabilization in clinical signs and symptoms of disorder ; **AND**
III. Individual is currently utilizing or has utilized non-drug treatment measures, such as psychosocial intervention/care, in the previous 12 months; **AND**
IV. Prescriber is monitoring laboratory values for metabolic side effects at least annually; **AND**
V. Prescriber is monitoring body weight and BMI at least quarterly; **AND**
VI. Prescriber is regularly monitoring for neurological side effects.

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Market Applicability							
Market	**DC**	**GA**	**KY**	**MD**	**NJ**	**NY**	**WA**
Applicable	X	X	X	NA	X	X	X

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11.

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