Pharmacy Policy

Antipsychotics

Policy Number: 9.503
Revision Number: R1
Version Effective Date: 1/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☒ New Hampshire Medicaid	☐ MassHealth - MCO ☐ MassHealth - ACO ☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

Products Affected:

- **aripiprazole ODT**
- **aripiprazole Sol**
- **clozapine ODT**
- **risperidone ODT**
- **olanzapine ODT**
- **Fanapt (iloperidone)**
- **paliperidone**
- **Latuda (lurasidone)**
- **Nuplazid (pimavanserin)**
- **Saphris (asenapine)**
- **Rexulti (brexpiprazole)**
- **Vraylar (cariprazine)**
- **Versacloz (clozapine)**
- **Secuado (asenapine)**

The Plan may authorize coverage of the above products for members meeting the following criteria:

Covered Use	• All FDA approved indications not otherwise excluded • All indications supported by established clinical literature for the medical condition and age
Exclusion	None

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name Well Sense Health Plan.

Criteria	
Required Medical Information	**clozapine ODT, risperidone ODT, olanzapine ODT, aripiprazole ODT, aripiprazole sol** 1. A diagnosis of bipolar disorder, schizophrenia, or other psychotic disorder; ***OR*** 2. A diagnosis of major depression requiring adjunct therapy (aripiprazole ODT, aripiprazole sol only); ***AND*** 3. Clinical swallowing difficulties (including unwillingness to swallow tablets **Paliperidone** 1. A diagnosis of schizophrenia, or other psychotic disorder **Fanapt, Latuda, Vraylar, Versacloz** 1. A diagnosis of bipolar disorder, schizophrenia, or other psychotic disorder; ***AND*** 2. An inadequate response, intolerance or contraindication to a trial of one agent from Behavioral Health- Atypical Antipsychotics and Combos class- (See appendix A) **Nuplazid** 1. A diagnosis of Parkinson's disease psychosis. **Rexulti** 1. *A* diagnosis of bipolar disorder, schizophrenia or other psychotic disorder, or major depression requiring adjunct therapy; ***AND*** 2. An inadequate response, intolerance or contraindication to a trial of one agent from Behavioral Health- Antipsychotics and Combos class- (See Appendix A) **Saphris** 1. A diagnosis of bipolar disorder, schizophrenia or other psychotic disorder; ***AND*** 2. An inadequate response, intolerance or contraindication to a trial of one agent from Behavioral Health- Atypical Antipsychotics and Combos class- (See Appendix A) **Secuado** 1. A diagnosis of Schizophrenia; ***AND*** ***2.*** An inadequate response, intolerance or contraindication to a trial of at least 2 agents from Behavioral Health – Atypical Antipsychotics and Combos class – (See Appendix A); ***AND*** 3. Evidence or attestation from the provider that oral therapy may not be suitable
Age Restriction	Secuado: 18 years and older
Prescriber	None

Restriction	
Coverage Duration	Initial:24 months
Other criteria	None

Appendix A – Preferred Drugs

Behavioral Health- Atypical Antipsychotics and Combos
Abilify Maintena
Aripiprazole/ODT/solution (ODT/Sol require PA)
Aristada
clozapine
clozapine ODT (Requires PA)
Invega Sustenna/Trinza
Olanzapine/ODT (ODT requires PA)
olanzapine/fluoxetine
Paliperidone (requires PA)
Quetiapine IR/ER
Risperdal Consta
Risperidone IR/ODT (ODT requires PA)
ziprasidone

Clinical Background Information and References

1. Lehman AF, et al. Practice guideline for the treatment of patients with schizophrenia, second edition. American Psychiatric Association. Apr 2004;1-184. Available from: http://psychiatryonline.org/guidelines.aspx.
2. Prescribing Information. Saphris (asenapine). Merck Co., Inc. Whitehouse Station, NJ. September 2010.
3. Jibson MD. Second-generation antipsychotic medications: Pharmacology, administration, and comparative side effects. Up to Date®, accessed August 2015; available from http://www.uptodate.com
4. Prescribing Information. Latuda® (lurasidone). Sunovion Pharmaceuticals Inc. Fort Lee, NJ. October 2010; updated July 2013
5. Bobo WV, Shelton RC. Bipolar disorder in adults: Treating major depression with second-generation antipsychotics. Up to Date®, accessed August 2015; available from http://www.uptodate.com
6. Nelson C. Unipolar depression in adults: Treatment with second-generation antipsychotics. Up to Date®, accessed August 2015; available from http://www.uptodate.com

7. Prescribing Information. Versacloz™ (clozapine oral suspension). Jazz Pharmaceuticals. Palo Alt, CA. August 2013.
8. Vraylar (cariprazine) [prescribing information]. Parsippany, NJ: Actavis Pharma; September 2015
9. Nuplazid (pimavanserin) [prescribing information]. San Diego, CA: Acadia Pharmaceuticals Inc: April 2016.

Original Approval Date	Original Effective Date	Policy Owner	Approved by
12/1/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee, NH DHHS

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
12/1/2020	9.152 Antipsychotics Policy retired, new policy created; updated policy to align with NH state PDL; slightly updated criteria for Secuado; created Appendix A; updated QL table;	1/1/2021	P&T Committee, NH DHHS

Next Review Date

2021

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

Disclaimer Information

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers

in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.