**Pharmacy Policy**

# Antipsychotics

**Policy Number:** 9.503
**Version Number:** 2.1
**Version Effective Date:** 9/1/2021

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

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

## Prior Authorization Policy

**Products Affected:**

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

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

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| **Covered Use** | • All FDA approved indications not otherwise excluded<br>• All indications supported by established clinical literature for the medical condition and age |

[+] *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.

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| **Exclusion Criteria** | None |
| **Required Medical Information** | **clozapine ODT, risperidone ODT, aripiprazole ODT, aripiprazole sol, Versacloz**<br>1. A diagnosis of bipolar disorder, schizophrenia, or other psychotic disorder; ***OR***<br>2. A diagnosis of major depression requiring adjunct therapy ( aripiprazole ODT, aripiprazole sol only); ***AND***<br>3. Clinical swallowing difficulties (including unwillingness to swallow tablets)<br><br>**Fanapt, palipedione (oral), Latuda, Vraylar**<br>1. A diagnosis of bipolar disorder, schizophrenia, or other psychotic disorder; ***AND***<br>2. An inadequate response, intolerance or contraindication to a trial of two covered atypical antipsychotics (See Appendix A)<br><br>**Nuplazid**<br>1. A diagnosis of Parkinson's disease psychosis.<br><br>**Rexulti**<br>1. A diagnosis of bipolar disorder, schizophrenia or other psychotic disorder; ***AND***<br>2. An inadequate response, intolerance or contraindication to a trial of at least 2 covered atypical antipsychotics (See Appendix A); ***OR***<br>3. A diagnosis of major depression requiring adjunct therapy; ***AND***<br>4 An inadequate response, intolerance or contraindication to a trial of at least 2 antidepressants from two different drug categories and one covered atypical antipsychotic agent (See Appendix A and B)<br><br>**Asenapine Maleate**<br>1. A diagnosis of bipolar disorder, schizophrenia or other psychotic disorder; ***AND***<br>2. An inadequate response, intolerance or contraindication to a trial of 2 covered atypical antipsychotics (See Appendix A); ***OR***<br>3. Clinical swallowing difficulties (including unwillingness to swallow tablets); ***AND***<br>4. An inadequate response, intolerance, or contraindication to a trial of risperidone ODT or olanzapine ODT<br><br>**Secuado** |

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| | 1. A diagnosis of Schizophrenia; ***AND***<br>2. An inadequate response, intolerance or contraindication to a trial of at least 2 covered atypical antipsychotics (See Appendix A); ***AND***<br>3. Evidence or attestation from the provider that oral therapy may not be suitable |
| **Age Restriction** | Secuado: 18 years or older |
| **Prescriber Restriction** | None |
| **Coverage Duration** | 1 year |
| **Quantity Limit** | Appendix C |
| **Other criteria** | None |

Appendix A:

| **Covered Oral Atypical Antipsychotics** |
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| Aristada |
| Aripiprazole (tab/sol) |
| Clozapine (tab) |
| Olanzapine (tab) |
| Quetiapine (IR tab) |
| Risperidone (tab/sol) |
| Ziprasidone(cap) |

Appendix B:

| **Covered Antidepressants** |
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| Bupropion |
| Citalopram (tab) |
| Duloxetine(cap- generic for Cymbalta) |
| Escitalopram(tab/sol) |
| Fluoxetine (cap/sol) |
| Fluvoxamine (tab) |
| Mirtazapine(tab) |
| Paroxetine (IR/ER tab) |

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| Venlafaxine ( ER cap/IR tab) |

Appendix C:

| **Drug** | **Quantity Limits** |
|---|---|
| Aripiprazole solution | 750ml per 30 days |
| aripiprazole orally disintegrating tablet | 60 tablets per 30 days |
| asenapine maleate | 60 tablets per 30 days |
| Clozapine orally disintegrating tablet 25mg, 100mg | 270 tablets per 30 days |
| Clozapine orally disintegrating tablet 12.5 mg | 90 tablets per 30 days |
| Clozapine orally disintegrating tablet 150mg | 180 tablets per 30 days |
| Clozapine orally disintegrating tablet 200mg | 120 tablets per 30 days |
| Fanapt | 60 tablets per 30 days |
| Latuda 20 mg, 40 mg, 60 mg, 120 mg | 30 tablets per 30 days |
| Latuda 80 mg | 60 tablets per 30 days |
| Nuplazid 10 mg and 34 mg | 30 capsules per 30 days |
| Nuplazid 17 mg | 60 capsules per 30 days |
| olanzapine orally disintegrating tablet 5mg, 10 mg, 15 mg, 20 mg | 30 tablets per 30 days |
| paliperidone tablet 1.5 mg, 3 mg, 9 mg | 30 tablets per 30 days |
| paliperidone tablet 6 mg | 60 tablets per 30 days |
| Rexulti | 30 tablets per 30 days |
| risperidone orally disintegrating tablet 0.25 mg, 0.5 mg, 1 mg, 2mg, 3 mg, 4 mg | 60 tablets per 30 days |
| Secuado | 30 patches per 30 days |
| Versacloz | 540 ml per 30 days |
| Vraylar | 30 capsules per 30 days |

## 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 |

| Policy Revisions History | | | |
|---|---|---|---|
| **Review Date** | **Summary of Revisions** | **Revision Effective Date** | **Approved by** |
| 12/1/2020 | 9.152 Antipsychotics Policy retired, new policy created; added appendix A and B; updated QL table; | 1/1/2021 | P&T Committee |
| 2/11/2021 | Annual policy review, updated coverage duration from 2 years to 1 year. Added generic asenapine maleate to policy to reflect generic availability of Saphris, brand name Saphris moved to NF | 6/1/2021 | P&T Committee |
| 3/29/2021 | Removed olanzapine ODT from policy because it is on the step therapy policy | 3/29/2021 | P&T Committee |
| 7/22/2021 | Abilify Maintena, Zyprexxa Relprevv and Risperdal Consta removed from policy. On state UPPL policy 9.057 | 9/1/2021 | P&T Committee |

## Next Review Date

2/2022

## Other Applicable Policies

Pediatric Behavioral Health Medication Initiative
Antipsychotics – Unified Formulary
Quantity Limit Exceptions

## 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.