

ATYPICAL ANTIPSYCHOTICS PA SUMMARY

PREFERRED	Geodon, Invega, Risperdal Tablets, Risperdal Solution, Seroquel, Seroquel XR
NON-PREFERRED	Abilify, Abilify Discmelt, Fanapt, Risperdal Consta, Risperdal-M Tabs, risperidone tablets (generic), risperidone ODT (generic), risperidone solution (generic), Symbyax, Zyprexa, Zyprexa Zydis
NON-PREFERRED (PA Not Required)	Clozaril, Clozapine, Fazaclo, Zyprexa Injection

LENGTH OF AUTHORIZATION: 1 YEAR

NOTE: *All members who have received a non-preferred medication in this category (with the exception of generic risperidone tablets and solution) are grandfathered on that medication. The member must have at least one claim for the requested non-preferred product within the last 12 months of claims history, except Risperdal Consta which required prior use within the past 90 days for grandfathering purposes. Physicians discharging a member from an inpatient facility stable and responding to a non-preferred agent should request prior authorization as part of the patient's discharge planning.*

PA CRITERIA:

- ❖ For Abilify or Zyprexa, must be able to demonstrate patient use (for at least a thirty day treatment period each) of 3 preferred agents within the last 12 months or provider should be prepared to provide clinical justification as to why use of the preferred drugs would constitute unacceptable therapy for the patient.
- ❖ For Abilify or Zyprexa, patients with a diagnosis of Bipolar Disorder or Schizophrenia with a family history of successful treatment on these agents will also be an approvable condition.
- ❖ For Fanapt, patients 18 years of age or older, with a diagnosis of Schizophrenia must be able to demonstrate use (for at least a thirty day treatment period each) of 3 preferred agents within the last 12 months or provider should be prepared to provide clinical justification as to why use of the preferred drugs would constitute unacceptable therapy for the patient. Approval will also be considered for patients with an immediate family member that has been successfully treated on Fenapt.
- ❖ For Symbyax, an atypical antipsychotic and an antidepressant should be used as two separate products.
- ❖ For Risperdal Consta, the member must have a diagnosis of Bipolar Disorder or Schizophrenia. In addition, documentation should be submitted to demonstrate either the patient has already been started and stabilized on this medication or they have already tried and failed or been noncompliant on the oral dosage form of this medication.

- ❖ For orally disintegrating dosage formulations (Abilify Discmelt, Risperdal M-Tab, or Zyprexa Zydis), the non-disintegrating oral dosage formulation should be used.
- ❖ For generic Risperidone tablets or solution, physician should submit documentation of allergies, contraindications, drug-drug interactions, or show a history of intolerable side effects to the inactive ingredients in brand name Risperdal (preferred medication).

EXCEPTIONS:

- ❖ Physicians can request approval for patients which have been started and stabilized on a non-preferred product for a reasonable period of time prior to becoming Medicaid eligible or during hospitalization. It should be noted that use of samples does not constitute stabilization.
- ❖ Exceptions to these conditions of coverage are considered through the prior authorization process.
- ❖ The Prior Authorization process may be initiated by calling **SXC Health Solutions at 1-866-525-5827**.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to www.ghp.georgia.gov, select the Provider Information tab, click on “view full text” in the Pharmacy Services box, click on “Prior Approval Process” in the list on the left.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to www.ghp.georgia.gov, select Provider Information, click on “view full list” in the Medicaid Provider Manuals box then select Pharmacy Services from the list shown.