

ATYPICAL ANTIPSYCHOTICS PA SUMMARY

PREFERRED	Geodon, risperidone generic, Seroquel IR
NON-PREFERRED	Abilify, Abilify Discmelt, clozapine generic, Fanapt, FazaClo, Invega, Invega Sustenna, Latuda, olanzapine generic, Risperdal Consta, Risperdal-M Tab, Saphris, Seroquel XR, Symbyax, Zyprexa, Zyprexa Relprevv, Zyprexa Zydis

LENGTH OF AUTHORIZATION: 6 Months to 1 Year

NOTE:

- ❖ *Prior authorization (PA) is not required for preferred products (Geodon, risperidone generic, Seroquel IR), clozapine or FazaClo for members that are within FDA-approved ages. For members between the ages of 5-16 using risperidone generic for autism irritability, PA is not required if the ICD-9 code of 299.0 is provided on the prescription for the pharmacy to enter at the point-of-sale.*
- ❖ *Prior authorization is not required for brand short-acting injections (Abilify, Geodon, Zyprexa). Generic olanzapine short-acting injection requires PA with a written letter of medical necessity stating the reasons the brand Zyprexa short-acting injection is not appropriate for the member.*
- ❖ *If generic olanzapine tablets or ODT is requested and approved, the PA will be entered for the brand product, Zyprexa tablets or Zyprexa Zydis.*
- ❖ *For all products requiring PA, a monitoring plan for safety and effectiveness is required.*
- ❖ *For **all** members younger than FDA-approved ages, PA must be requested by completing the Atypical Antipsychotic Prior Authorization Request Form and **faxing to SXC Health Solutions at 888-491-9742**. Letter of medical necessity information should include diagnosis, medical and medication history, improvement in symptoms while on medication, monitoring plan and any other information or documentation supporting the use of the medication.*
- ❖ *The Atypical Antipsychotic PA Request Form is located at <http://dch.georgia.gov/pharmacy> > Prior Authorization Process and Criteria or directly at http://dch.georgia.gov/00/channel_title/0,2094,31446711_43293586,00.html.*
- ❖ *For medications requiring PA, an extension of therapy may be requested for members that have been on therapy and are being tapered off of medication for discontinuation, for members that have been on therapy and whose PA is under review for age appropriateness, and for members that have been on therapy and are being referred to a psychiatrist and are awaiting an appointment.*
- ❖ *Physicians discharging a member from an inpatient facility stable and responding to a non-preferred agent should request PA as part of the patient's discharge planning.*
- ❖ *If an injectable medication is being administered in a physician's office or clinic then it must be billed through the DCH physician's injectable program and not*

the outpatient pharmacy program. Information regarding the physician's injectable program can be located at www.mmis.georgia.gov/portal.

PA CRITERIA:

For Geodon capsules, clozapine generic, FazaClo, risperidone generic (tablets, ODT, oral solution), Seroquel IR

- ❖ ***Prior authorization for members within FDA-approved ages is not required.***

For Abilify tablets and oral solution

- ❖ *For members 18 years or older with a diagnoses of Bipolar Disorder, must demonstrate prior use (for at least a thirty day treatment period each) of the 3 preferred agents within the last 12 months or physician must provide clinical justification as to why the preferred drugs are unacceptable therapy for the member. For members 10-17 years old, must demonstrate prior use of risperidone generic and Seroquel IR or physician must provide clinical justification as to why risperidone generic and Seroquel IR are unacceptable therapy for the member.*
- ❖ *For members 18 years or older with a diagnosis of Schizophrenia, must demonstrate prior use (for at least a thirty day treatment period each) of the 3 preferred agents within the last 12 months or physician must provide clinical justification as to why the preferred drugs are unacceptable therapy for the member. For members 13-17 years old, must demonstrate prior use of risperidone generic and Seroquel IR or physician must provide clinical justification as to why risperidone generic and Seroquel IR are unacceptable therapy for the member.*
- ❖ *For members 6-17 years old with a diagnosis of Irritability Associated with Autism, must demonstrate prior use (for at least a thirty day treatment period) of risperidone generic within the last 12 months or physician must provide clinical justification as to why risperidone generic is unacceptable therapy for the member.*
- ❖ *For members 18 years or older with a diagnosis of Adjunctive Therapy for Major Depressive Disorder, prior use of the following is required: two selective serotonin reuptake inhibitors (SSRIs), venlafaxine/Effexor, and Cymbalta.*

For Fanapt or Latuda

- ❖ *For members 18 years or older with a diagnosis of Schizophrenia, must demonstrate prior use (for at least a thirty day treatment period each) of the 3 preferred agents within the last 12 months or physician must provide clinical justification as to why the preferred drugs are unacceptable therapy for the member.*

For Invega

- ❖ *For members 18 years or older with a diagnosis of Schizophrenia, must demonstrate prior use (for at least a thirty day treatment period each) of the 3 preferred agents within the last 12 months or physician must provide clinical*

justification as to why the preferred drugs are unacceptable therapy for the member. For members 12-17 years old, must demonstrate prior use of risperidone generic and Seroquel IR or physician must provide clinical justification as to why risperidone generic and Seroquel IR are unacceptable therapy for the member.

For Invega Sustenna

- ❖ Members must be 18 years or older, have a diagnosis of Schizophrenia and be under treatment by or in consultation with a psychiatrist. In addition, documentation must be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has history of noncompliance or member is unable to swallow oral dosage forms.

For Generic Olanzapine Short-Acting Injection

- ❖ A written letter of medical necessity is required stating the reasons the brand Zyprexa short-acting injection is not appropriate for the member.

For Risperdal Consta

- ❖ Members must be 18 years or older, have a diagnosis of Bipolar Disorder or Schizophrenia and be under treatment by or in consultation with a psychiatrist. In addition, documentation must be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has history of noncompliance or member is unable to swallow oral dosage forms.

For Saphris

- ❖ Members must be 18 years or older with a diagnosis of Bipolar Disorder or Schizophrenia and have difficulty swallowing regular oral dosage forms or need monitoring by caregiver to ensure compliance. Physician must also provide clinical justification as to why risperidone ODT generic is unacceptable therapy for the member.

For Seroquel XR

- ❖ For members 18 years or older with a diagnosis of Bipolar Disorder or Schizophrenia, physician must submit documentation of allergies, contraindications, drug-drug interactions or a history of intolerable side effects to the inactive ingredients of Seroquel IR and must demonstrate prior use (for at least a thirty day treatment period each) of Geodon and risperidone generic within the last 12 months or must provide clinical justification as to why the preferred drugs are unacceptable therapy for the member.
- ❖ For members 18 years or older with the diagnosis of Adjunctive Therapy for Major Depressive Disorder, prior use of each of the following is required: two SSRIs, venlafaxine/Effexor, and Cymbalta.

For Symbyax

- ❖ For members 18 years or older with a diagnosis of Bipolar Disorder, an atypical antipsychotic and an antidepressant should be used as two separate products.
- ❖ For members 18 years or older with a diagnosis of Treatment-Resistant Major Depressive Disorder, prior use of each of the following is required: two SSRIs, venlafaxine/Effexor, and Cymbalta.

For Zyprexa or generic olanzapine tablets

- ❖ For members 18 years or older with a diagnoses of Bipolar Disorder or Schizophrenia, must be able to demonstrate prior use (for at least a thirty day treatment period each) of the 3 preferred agents within the last 12 months or must provide clinical justification as to why use of the preferred drugs are unacceptable therapy for the member. Members 13-17 years old must demonstrate prior use of risperidone generic and Seroquel or must provide clinical justification as to why risperidone generic and Seroquel IR are unacceptable therapy for the member.

For Zyprexa Relprevv

- ❖ Member must be 18 years or older, have a diagnosis of Schizophrenia and be under treatment by or in consultation with a psychiatrist. In addition, documentation should be submitted to demonstrate one of the following: the member has already been started and stabilized on this medication, member has a history of noncompliance or member is unable to swallow oral dosage forms.

For Orally Disintegrating Dosage Forms other than Saphris

- ❖ For orally disintegrating dosage formulations (Abilify Discmelt, Risperdal M-Tab, Zyprexa Zydis or generic olanzapine ODT), the non-disintegrating oral dosage formulation should be used. Exceptions may be made for members with difficulty swallowing regular oral dosage forms or needs monitoring by caregiver to ensure compliance if the member meets the criteria for the non-disintegrating oral dosage formulation. Physician must also provide clinical justification as to why risperidone ODT generic is unacceptable therapy for the member. A written letter of medical necessity is required for Risperdal M-Tab stating the reasons that risperidone ODT generic is not appropriate for the member.

EXCEPTIONS:

- ❖ Physicians can request approval for members 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 for members within FDA-approved ages may be initiated by **calling SXC Health Solutions at 1-866-525-5827**.
- ❖ The Prior Authorization process for members younger than FDA-approved ages must be initiated by completing the Atypical Antipsychotic Prior Authorization Request Form and **faxing to SXC Health Solutions at 1-888-491-9742**. The Atypical Antipsychotic Prior Authorization Request Form can be found at <http://dch.georgia.gov/pharmacy> > Prior Authorization Process and Criteria or directly at http://dch.georgia.gov/00/channel_title/0,2094,31446711_43293586,00.html.

PA and APPEAL PROCESS:

- ❖ For online access to the PA process please go to www.mmis.georgia.gov/portal, highlight the pharmacy link on the top right side of the page, and click on “prior approval process”.

QUANTITY LEVEL LIMITATIONS:

- ❖ For online access to the current Quantity Level Limit please go to www.mmis.georgia.gov/portal, highlight Provider Information and click on Provider Manuals. Scroll to the page with Pharmacy Services Part II and select that manual.