GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ATYPICAL ANTIPSYCHOTICS PA SUMMARY

Preferred	Non-Preferred
Oral	
Aripiprazole tablets, oral solution generic Asenapine sublingual tablets generic Caplyta (lumateperone) Clozapine tablets generic Fanapt (iloperidone) Lurasidone generic Olanzapine generic Paliperidone generic Quetiapine IR and ER generic Rexulti (brexpiprazole)* Risperidone generic Vraylar (cariprazine)* Ziprasidone generic	Lybalvi (olanzapine/samidorphan) Nuplazid (pimavanserin)
Injectable	
Abilify Asimtufii (aripiprazole extended-release injection)* Abilify Maintena (aripiprazole extended-release injection)* Aristada/Aristada Initio (aripiprazole lauroxil extended-release injection)* Geodon (ziprasidone short-acting injection) Invega Hafyera (paliperidone extended-release injection)* Invega Sustenna (paliperidone extended-release injection)* Invega Trinza (paliperidone extended-release injection)* Olanzapine short-acting injection generic Perseris (risperidone extended-release injection)* Risperdal Consta (risperidone long-acting injection)* Rykindo (risperidone extended-release injection)*Uzedy (risperidone extended-release injection)* Zyprexa Relprevv (olanzapine long-acting injection)*	n/a

*Preferred agents that require PA for select diagnoses, IR=immediate-release, ER=extended-release, ODT=orally disintegrating tablets

LENGTH OF AUTHORIZATION: 6 months to 1 year

NOTES:

- Prior authorization (PA) is not required for the following preferred products: aripiprazole tablets and oral solution generic, asenapine sublingual tablets generic, clozapine generic, Fanapt, lurasidone generic, olanzapine generic, paliperidone generic, quetiapine IR and ER generic, risperidone generic and ziprasidone generic for members that are within FDA-approved ages. For members aged 5 years or older taking risperidone generic for pervasive developmental disorders (PDD)/autism or irritability associated with autism/PDD, PA is not required if the applicable ICD-10 code is provided on the prescription for the pharmacy to enter at the point-of-sale. For members aged 6 years or older taking generic aripiprazole tablets or oral solution for PDD/autism or irritability associated with autism/PDD, PA is not required if the applicable ICD-10 code is provided on the prescription for the pharmacy to enter at the point-of-sale. For members aged 13 years or older taking Rexulti for schizophrenia/schizoaffective disorder, PA is not required. For members aged 18 years or older taking Vraylar for schizophrenia/schizoaffective disorder or bipolar disorder, PA is not required.
- Prior authorization is not required for short-acting injections (Geodon and olanzapine generic).
- For all members younger than FDA-approved ages, PA must be requested by completing the Atypical Antipsychotic Prior Authorization Request Form and **faxing to OptumRx 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/prior-authorization-process-and-criteria.
- For products 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 stable member from an inpatient facility that has responded to a non-preferred agent should request PA as part of the member's discharge plan.
- **The criteria details below are for the outpatient pharmacy program.** If a medication is being administered in a physician's office or clinic, then the medication must be billed through the DCH physician services program and not the outpatient pharmacy program. Information regarding the physician services program is located at www.mmis.georgia.gov.

PA CRITERIA:

Oral Agents

Aripiprazole Tablets and Oral Solution Generic, Asenapine Sublingual Tablets Generic, Clozapine Generic, Fanapt, Lurasidone Generic, Olanzapine Generic, Paliperidone Generic, Risperidone Generic, Quetiapine IR Generic, Quetiapine ER Generic and Ziprasidone Generic

- ❖ Prior authorization for members within FDA-approved ages is not required.
- ❖ Prior authorization for members outside of FDA-approved ages requires the Atypical Antipsychotic Prior Authorization Form to be completed.

Lybalvi

- For members 18 years of age or older with a diagnosis of manic or mixed episodes associated with bipolar I disorder, schizophrenia or schizoaffective disorder who are treatment-naïve to olanzapine but are expected to experience undesirable weight gain attributable to treatment with olanzapin**e**, must have experienced ineffectiveness, allergies, contraindications, drug-drug interactions or intolerable side effects with at least 1 of the following preferred agents: aripiprazole, Fanapt, lurasidone, paliperidone, quetiapine IR/ER, risperidone, or ziprasidone.

Nuplazid

- For members 40 years of age or older with diagnosis of hallucinations and/or delusions associated with Parkinson's disease psychosis, prescriber must first attempt to adjust member's antiparkinson medication in order to reduce psychosis without worsening motor symptoms.
- Must be prescribed by or in consultation with a geriatrician, neurologist, or psychiatrist.

Rexulti

- For members 18 years of age or older with a diagnosis of major depressive disorder (MDD), must have had an inadequate response to at least 1 antidepressant, aripiprazole, or quetiapine ER and must use concurrently with an antidepressant.
- For members 40 years of age or older with a diagnosis of agitation associated with dementia due to Alzheimer's disease, must have had an inadequate response to at least 1 selective serotonin reuptake inhibitor (SSRI) or one preferred atypical antipsychotic.

Vraylar

- For members 18 years of age or older with a diagnosis of MDD, must have had an inadequate response to at least 1 antidepressant, aripiprazole, or quetiapine ER and must use concurrently with an antidepressant.

Injectable Agents

Abilify Asimtufii and Abilify Maintena

- Member must be 18 years of age or older, have a diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder and be under treatment by or in consultation with a psychiatrist as well as member has already been started and stabilized on the medication.

Aristada and Aristada Initio

- Member must be 18 years of age or older, have a diagnosis of schizophrenia or schizoaffective disorder and be under treatment by or in consultation with a psychiatrist as well as member has already been started and stabilized on the medication.
- In addition, Aristada Initio is only approvable for members initiating or re-initiating Aristada.

Invega Hafyera

- Members must be 18 years of age or older, have a diagnosis of schizophrenia or schizoaffective disorder and be under treatment by or in consultation with a psychiatrist. In addition, member must have been established on Invega Sustenna for at least 4 months or Invega Trinza for at least 3 months.

Invega Sustenna

- ❖ Members must be 18 years of age or older, have a diagnosis of schizophrenia or schizoaffective disorder and be under treatment by or in consultation with a psychiatrist as well as member has already been started and stabilized on this medication.

Invega Trinza

- ❖ Members must be 18 years of age or older, have a diagnosis of schizophrenia or schizoaffective disorder and be under treatment by or in consultation with a psychiatrist. In addition, member must have been established on Invega Sustenna for at least 4 months.

Perseris and Uzedy

- ❖ Members must be 18 years of age or older, have a diagnosis of schizophrenia or schizoaffective disorder and be under treatment by or in consultation with a psychiatrist as well as member has already been started and stabilized on this medication.

Risperdal Consta and Rykindo

- ❖ Members must be 18 years of age or older, have a diagnosis of schizophrenia, schizoaffective disorder or bipolar disorder and be under treatment by or in consultation with a psychiatrist as well as member has already been started and stabilized on this medication.

Zyprexa Relprevv

- ❖ Member must be 18 years of age or older, have a diagnosis of schizophrenia or schizoaffective disorder and be under treatment by or in consultation with a psychiatrist as well as member has already been started and stabilized on this medication.
- ❖ Must be administered in a Risk Evaluation and Mitigation Strategies (REMS)-certified outpatient facility.

QLL CRITERIA:

- *For Clozapine, Clozapine ODT, FazaClo, Olanzapine, Quetiapine IR, Rexulti, Risperidone, and Ziprasidone:* An authorization to exceed the QLL may be granted if the member's dose is being titrated due to initiation of therapy. The physician should submit faxed documentation of the proposed titration schedule.
- Additionally, for *olanzapine 20mg*, an authorization to exceed the QLL may be granted if physician submits faxed documentation of evidence of refractory schizophrenia/schizoaffective disorder and evidence that the member is being monitored for increases in weight, blood glucose, and lipid panel.
- For *low-dose quetiapine IR* (25mg at doses of 1 or 2 tablets per day or 50mg at dose of 1 tablet per day), the physician must submit a written letter of medical necessity. The member must also not be using another strength of quetiapine IR, an antidepressant, or an antipsychotic.

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 OptumRx 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 OptumRx 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/prior-authorization-process-and-criteria.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.