AETNA BETTER HEALTH®
Prior Authorization guideline for Antipsychotics

Prior authorization is required for all agents when prescribed for patients who are under 18 years of age and for non-formulary agents when prescribed for patients 18 and older.

Requests for non-formulary agents regardless of age are approved when the clinical criteria outlined below is met AND the formulary alternatives have previously failed or are contraindicated.

Authorization guidelines

For Patients greater than 18 years old requesting NON-Formulary Atypical Antipsychotic:

I. Required for ALL indications:
   A. Antipsychotic is being prescribed by, or in consultation with a psychiatrist
   B. Antipsychotic is prescribed within FDA approved daily dosing guidelines.
   C. Documentation of baseline and routine monitoring of weight or body mass index (BMI), waist circumference, blood pressure, fasting glucose, fasting lipid panel and Extrapyramidal Symptoms (EPS) using Abnormal Involuntary Movement Scale (AIMS) is provided.

II. Additional criteria for Bipolar Disorder or Schizophrenia (ONE of the following):
   A. The patient had treatment failure on at least TWO preferred formulary atypical antipsychotics; OR
   B. The patient is currently stabilized on the antipsychotic and documentation is provided to support evidence of stabilization within the most recent 90 days.

III. Additional criteria for Major Depressive Disorder:
   A. Documentation of failure or unresponsiveness to THREE different antidepressants from at least TWO different therapeutic subclasses
   B. Patient meets ONE of the following: a. The patient had treatment failure on at least TWO preferred formulary atypical antipsychotics; OR
   C. The patient is currently stabilized on the antipsychotic and documentation is provided to support evidence of stabilization within the most recent 90 days.

For Patients 6-18 years old requesting any antipsychotic (traditional or atypical)
Requests for non-formulary agents require documentation of trial and failure or contraindication to the preferred formulary alternatives in addition to the diagnosis specific criteria listed below.

1) **Treatment of Bipolar Disorder or Schizophrenia**
   - i) The drug requested is a preferred formulary antipsychotic **AND**
   - ii) Has documented evidence of a comprehensive evaluation, including non pharmacologic therapies such as, but not limited to, evidence based behavioral, cognitive, and family based therapies **AND**
   - iii) Is Being prescribed by, or in consultation with:
     1. Pediatric neurologist
     2. Child and Adolescent Psychiatrist
     3. Child Development Pediatrician
     4. Adult or Adult and Adolescent Psychiatrist (for members age 14 and older) **AND**
   - iv) Has documented baseline monitoring off weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel and Extrapyramidal Symptoms (EPS) using Abnormal Involuntary Movement Scale (AIMS)

2) **Adjunctive treatment to antidepressants for Major Depressive Disorder**
   Documentation of failure or unresponsiveness to THREE different antidepressants from at least two different therapeutic subclasses **AND**
   - i) The drug requested is a preferred formulary antipsychotic **AND**
   - ii) Has documented evidence of a comprehensive evaluation, including non pharmacologic therapies such as, but not limited to, evidence based behavioral, cognitive, and family based therapies **AND**
   - iii) Is Being prescribed by, or in consultation with:
     1. Pediatric neurologist
     2. Child and Adolescent Psychiatrist
     3. Child Development Pediatrician
     4. Adult or Adult and Adolescent Psychiatrist (for members age 14 and older)
     5. **AND**
   - iv) Has documented baseline monitoring off weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel and Extrapyramidal Symptoms (EPS) using Abnormal Involuntary Movement Scale (AIMS)
3) Treatment of psychomotor agitation, irritability, aggression, or self-injurious behavior associated with autistic disorder:
   i) The drug requested drug is risperidone
   ii) OR If the request is for alternative formulary antipsychotic, then the Patient has documented failure or contraindication to risperidone, AND
   iii) Has documented evidence of a comprehensive evaluation, including non pharmacologic therapies such as, but not limited to, evidence based behavioral, cognitive, and family based therapies AND
   iv) Is Being prescribed by, or in consultation with :
      (1) Pediatric neurologist
      (2) Child and Adolescent Psychiatrist
      (3) Child Development Pediatrician
      (4) Adult or Adult and Adolescent Psychiatrist(for members age 14 and older)
      (5) AND
   v) Has documented baseline monitoring off weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel and Extrapyramidal Symptoms (EPS) using Abnormal Involuntary Movement Scale (AIMS)

4) Additional criteria for chronic tic disorder (including Tourette’s Syndrome):
   i) The drug requested is a formulary antipsychotic
   ii) Is Being prescribed by, or in consultation with :
      (1) Pediatric neurologist
      (2) Child and Adolescent Psychiatrist
      (3) Child Development Pediatrician
      (4) Adult or Adult and Adolescent Psychiatrist(for members age 14 and older)
      (5) AND
   iii) Has documented baseline monitoring off weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel and Extrapyramidal Symptoms (EPS) using Abnormal Involuntary Movement Scale (AIMS)

5) Aggression associated with disruptive behavior disorders, conduct disorders, or intellectual disabilities:
   The use of first and second generation antipsychotics is considered off label in these conditions and requests will be reviewed for Medical Necessity on case by case basis using the following criteria as guide.

NOTE: The limited long-term safety and efficacy data warrants careful consideration in children and adolescents. In the absence of specific FDA indications or substantial empirical support for the use of antipsychotics in this population of children and
adolescents, clinicians should consider other pharmacological or psychosocial
treatment modalities with more established efficacy and safety profiles prior to the
onset of antipsychotic use. There are almost no data about the use of antipsychotics in pre-school aged children

i) The drug requested is a formulary antipsychotic
ii) Is Being prescribed by, or in consultation with :
   (1) Pediatric neurologist
   (2) Child and Adolescent Psychiatrist
   (3) Child Development Pediatrician
   (4) Adult or Adult and Adolescent Psychiatrist(for members age 14 and older)

AND

iii) Has documented baseline monitoring off weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel and Extrapyramidal Symptoms (EPS) using Abnormal Involuntary Movement Scale (AIMS)

AND

iv) Has chart documented evidence of a comprehensive clinical evaluation of conditions; including
   (1) Treatment plan that comprehensively addresses of all behaviors and conditions;
   (2) The use of more established medications to treat underlying/comorbid conditions as applicable.

v) Has documentation that aggressive behaviors continue and are not responding to non-pharmacologic therapies such as, but not limited to, evidence based behavioral, cognitive, and family based therapies despite compliance and participation with these interventions by the member and their parent/guardian as applicable.

Children Age 5 and Under:
Most antipsychotics are not FDA approved for use in children ages 5 and under. The safety and efficacy in this age group has not been established and is not supported by the currently published peer-reviewed medical literature including the AACAP Practice Parameter for the Use of Antipsychotics in Children & Adolescents. Request for coverage of antipsychotics in children age 5 and under is generally not considered to be medically necessary. Requests will be reviewed on a case-by-case basis by the plan Medical Director.

*Trial Dose- 1st fills of any new start therapy will be limited to two 15 day supply quantities, to establish tolerance to the new therapy prior to continuation. Subsequent refills will revert to usual full 1 month quantities

Authorization and Limitations
Initial Approval: 3 months
Renewal Approval Duration:
• Indefinitely for age 18 and older
• 1 year for ages 6-17
  o Renewals require documentation of the following:
    ▪ Improvement in target symptoms
    ▪ Treatment plan that contains either plan for discontinuation or rationale for continued use
    ▪ Annual follow-up monitoring for EPS using AIMS
    ▪ Follow-up metabolic monitoring:
      • Weight/BMI: monthly for the first 3 months
      • Waist circumference: annually
      • Blood pressure and fasting glucose: at 3 months then annually
      • Fasting lipids: at 3 months

Additional Information:
Atypical Antipsychotics are NOT covered for members with the following criteria:
  • Use not approved by the FDA; **AND**
  • The use is unapproved and not supported by the literature or evidence as an accepted off-label use.

**Medically Necessary** — A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

  • The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

  • The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

  • The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member’s family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.
References:


