AETNA BETTER HEALTH®
Prior Authorization guideline for Oral Atypical Antipsychotics

**Formulary:**
clozapine
olanzapine
quetiapine
risperidone
ziprasidone

**Non-Formulary:**
ariptoprazole
Fanapt
Latuda
paliperidone ER
quetiapine ER
Rexulti
Saphris
Vraylar

**Members under 18 years of age:** Prior authorization is required for all agents.

**Members 18 years of age and older:** Prior authorization is required for non-preferred agents.

**Continuity of Care:**
- Members 18 years or older started on a non-formulary atypical antipsychotic during a recent hospitalization will receive a 90-day approval (requests for continued use after 90 days are considered renewals).
- Members 18 years or older who are new to the plan and stable on a non-formulary antipsychotic will receive a 6-month approval. Medication must be prescribed for an FDA approved or compendia
supported indication and dosing (*requests for continued use are considered renewals*).

- Members 6-17 years old started on a non-formulary atypical antipsychotic will not be required to try formulary alternatives. Applicable clinical criteria for this age group still apply.

**Authorization guidelines**

**For children under the age of 18 years, documentation of ALL the following:**

A. Antipsychotic is prescribed within FDA approved daily dosing, recognized treatment guidelines or recognized compendia.

B. Member has severe behavioral problems related to psychotic or neurodevelopmental disorders such as seen in, but not limited to, the following diagnoses:
   1. Autism Spectrum Disorder, OR
   2. Intellectual disability, OR
   3. Conduct Disorder, OR
   4. Bipolar disease, OR
   5. Tic Disorder, including Tourette’s Syndrome, OR
   6. Transient encephalopathy, OR
   7. Schizophrenia
   
   AND

C. If less than 14 years of age, is being prescribed the medication by, or in consultation with a:
   1. Pediatric Neurologist, OR
   2. Child and Adolescent Psychiatrist, OR
   3. Child Development Pediatrician
   
   OR

D. If 14 years of age or older, is being prescribed the medication by, or in consultation with, a:
1. Pediatric Neurologist, OR
2. Child and Adolescent Psychiatrist, OR
3. Child Development Pediatrician, OR
4. General Psychiatrist

AND

E. Has chart 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

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

AND

G. For therapeutic duplication of an Atypical Antipsychotic:
   1. Member is being titrated to, or tapered from, a drug in the same class
      OR
   2. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested

AND

H. Documentation of one of the following:
   1. The requested antipsychotic is a preferred formulary agent
      OR
   2. Member had an inadequate response, or intolerable side effects or contraindication to two (2) preferred formulary atypical antipsychotics
      OR
3. Member is currently stabilized on non-preferred agent

**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.

**Non-Preferred Agents – Adults Age 18 and older:**

A. Antipsychotic is prescribed within FDA approved daily dosing, recognized treatment guidelines or recognized compendia.

   AND

B. Baseline and yearly monitoring of blood glucose using a test for hemoglobin A1c (HBA1c) or blood glucose

   AND

C. Baseline and yearly monitoring of cholesterol using a test of low-density lipoprotein-cholesterol (LDL-C) or cholesterol

   AND

D. Weight at baseline and yearly

   AND

E. Screening for movement disorders associated with antipsychotic therapy

   AND

F. Additional criterion for Bipolar Disorder or Schizophrenia: Member had treatment failure, contraindication or intolerance on at least two (2) preferred formulary atypical antipsychotics OR Member is stabilized on the non-preferred agent requested

   AND

G. Additional criteria for Major Depressive Disorder:

   1. Member stabilized on the non-preferred agent requested

      OR
2. Member had an inadequate response, or intolerable side
effects or contraindication to at least three (3) different
medication regimens for depression at an adequate dose
and duration (at least 4 weeks):
   a. Antidepressant monotherapy
   b. Antidepressant augmentation (SSRI or SNRI plus any
      of the following: bupropion, lithium, buspirone, or
      liothyronine)
   AND
3. Member meets one of the following:
   a. The requested antipsychotic is a preferred formulary
      agent
      OR
   b. Member had an inadequate response, or intolerable
      side effects or contraindication to, at least two (2)
      preferred formulary atypical antipsychotics

Authorization and Limitations

Initial Approval: 6 months for members 18 years old or older; 3 months for
members under 18 years old

Renewal Approval Duration: One year
- Renewals require documentation of the following:
  o Improvement in target symptoms
  o Treatment plan that contains either plan for discontinuation or rationale
    for continued use
  o Member weight
  o Screen for movement disorders
  o Metabolic screen

Quantity Limits:
- Aripiprazole
  QLL 30/30
- Fanapt
  QLL 60/30
- Latuda

Last Review: 1/2019
Previous PARP Approval: 6/2018
Current PARP Approval: 3/2019
• **Olanzapine**  
  QLL 30/30: 2.5mg, 5mg, 7.5mg, 10mg, 15mg 20mg
• **Paliperidone ER**  
  QLL 30/30: 1.5mg, 3mg, 9mg  
  QLL 60/30: 6mg
• **Quetiapine**  
  QLL 90/30: 25mg, 50mg, 200mg, 300mg  
  QLL 60/30: 400mg
• **Quetiapine ER**  
  QLL 60/30: 50mg, 300mg, 400mg  
  QLL 30/30: 150mg, 200mg
• **Rexulti**  
  QLL 30/30
• **Risperidone**  
  QLL 60/30: 0.25mg, 0.5mg, 1mg, 2mg  
  QLL 90/30: 3mg  
  QLL 120/30: 4mg  
  QLL 480mL/30: 1mg/mL
• **Saphris**  
  QLL 60/30
• **Vraylar**  
  QLL 30/30
• **Ziprasidone**  
  QLL 60/30: 20mg, 40mg, 60mg, 80mg

**Additional Information:**

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.
- Use of more than one antipsychotic, unless supported by peer reviewed literature or national treatment guidelines or recognized compendia OR cross titration is needed for up to 60 days.

**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:


11. Hetrick SE, Cox GR, Witt KG, Bir JJ, Merry SN. Cognitive behavioural therapy (CBT), third-wave CBT and interpersonal therapy (IPT) based interventions for preventing depression in children and adolescents. Cochrane Database Syst


and-adolescents-pharmacologic-interventions?topicRef=608&source=see_link.


