AETNA BETTER HEALTH®
Prior Authorization guideline for Long-Acting Injectable Antipsychotics

Drugs Covered
- Abilify Maintena
- Aristada
- Invega Sustenna
- Invega Trinza
- Risperdal Consta
- Zyprexa Relprevv

Authorization guidelines

Continuity of Care will be allowed for the following conditions:
- Members 18 years or older started on an 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 treatment will receive a 12 month approval. Medication must be prescribed for an FDA approved or compendia supported indication and dosing (requests for continued use are considered renewals).

Documentation is required of ALL of the following:
A. Member is at least 18 years of age
B. Medication is prescribed by or in consultation with a psychiatrist
C. Member has received the recommended oral dosage (per FDA approved labeling) to confirm tolerability and efficacy prior to receiving the long-acting injectable medication
D. Member will not receive concomitant oral antipsychotics after the initial overlap period (per FDA approved labeling)
E. Medication will be used for an FDA-approved indication for the drug requested.
F. Member is not adherent with oral antipsychotic medications which places the member at risk for poor outcomes
G. Provider agrees to support baseline and routine monitoring of all the following:
   a. Weight, body mass index (BMI), or waist circumference
   b. blood pressure
   c. fasting glucose
   d. fasting lipid panel
   e. tardive dyskinesia using the Abnormal Involuntary Movement Scale (AIMS) or the Dyskinesia Identification System Condensed User Scale (DISCUS)
H. In addition for Abilify Maintena and Invega Trinza only: Member is not taking a CYP3A4 inducer
I. In addition for Invega Trinza only: Member had a trial with a stable dose of Invega Sustenna for 4 months to confirm tolerability and response

Additional Information:
These products 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.

Approval Duration:
Initial Approval:
1 year

Renewal:
1 year

Criterion for renewal: Documentation of metabolic screening within the last 60 days

Quantity Limits:
- Invega Sustenna: 1 per 28 days after initial loading doses
- Invega Trinza: 1 per 84 days
- Risperdal Consta: 2 per 28 days
- Abilify Maintena: 1 per 28 days
- Aristada: 1 per 28 days
- Aristada 886 mg: 1 per 28 days or 1 per 42 days
- Aristada 1,064mg: 1 per 2 months
- Zyprexa Relprevv 210mg and 300mg: 2 per 28 days
- Zyprexa Relprevv 405mg: 1 per 28 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.

Last Review: 4/2018
Previous PARP Approval: 10/2017
Current PARP Approval: 7/2018
• 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:
4. Zyprexa Relprevv [package insert]. Indianapolis, IN: LillyUSA, LLC: Revised 12/19/2014