AETNA BETTER HEALTH®

Prior Authorization guideline for Antipsychotics

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

Requests for non-formulary agents regardless of age are approved when the clinical criteria outlined below are met AND the formulary alternatives have previously failed or are contraindicated OR the member is currently stabilized on the antipsychotic and documentation is provided to support evidence of stabilization within the most recent 90 days.

The following interim authorizations may be granted upon notification of discharge from inpatient hospitalization to permit the documentation to support Medical Necessity per the guidelines that follow to be submitted and reviewed:

1) Members who started the antipsychotic during a recent hospitalization will receive a 90 day approval as continuity of care when prescribed for labeled indications and at FDA-approved doses.
2) Members who are new to the plan and are stable on the antipsychotic will receive a 6 month approval as continuity of care when prescribed for labeled indications and at FDA-approved doses.
3) Requests for continuity of care outside of the FDA-approved labeling may be approved for 30 days and will undergo Medical Director Review for medical necessity.

Authorization guidelines

For children 5 years old or younger:
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.

For children 6 - 18 years old:

Documentation of ALL of the following:
A. Antipsychotic is prescribed within FDA approved daily dosing, recognized treatment guidelines and recognized compendia.
B. Baseline and routine monitoring of weight, body mass index (BMI) or waist circumference, blood pressure, fasting glucose, fasting lipid panel, and tardive dyskinesia using the Abnormal Involuntary Movement Scale (AIMS) or Dyskinesia Identification System Condensed User Scale (DISCUS) has been completed.

C. Diagnosis was based on a comprehensive evaluation by a psychiatrist (members under 14 years must be seen by a child and adolescent psychiatrist), or pediatric neuropsychologist (or neurologist or developmental pediatrician for autism spectrum disorder or tic disorder) and the Member’s symptoms meet the Diagnostic and Statistical Manual of Mental Disorders (DSM5) criteria for that diagnosis.

D. Member continues to have residual symptoms despite use of evidence-based non-pharmacologic therapies such as behavioral, cognitive, and family based therapies (for new antipsychotic starts only)

E. Additional Criteria for Bipolar Disorder or Schizophrenia:
   1. The requested antipsychotic is a preferred formulary agent; OR
   2. Member had an inadequate response, or intolerable side effects or contraindication to, at least TWO preferred formulary atypical antipsychotics

F. Additional Criteria for Major Depressive Disorder:
   1. Member had an inadequate response, or intolerable side effects or contraindication to at least THREE 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)
      c. Member meets ONE of the following:
         i. The requested antipsychotic is a preferred formulary agent; OR
         ii. Member has had an inadequate response, or intolerable side effects or contraindication to, at least TWO preferred formulary atypical antipsychotics

G. Additional Criteria for psychomotor agitation, irritability, aggression, or self-injurious behavior associated with autistic disorder:
   1. The requested antipsychotic is a preferred formulary agent; OR
   2. Member has had an inadequate response, or intolerable side effects or contraindication to, at least TWO preferred formulary atypical antipsychotics

H. Additional criteria for chronic tic disorder (including Tourette’s Syndrome):
   1. The requested antipsychotic is a preferred formulary agent; OR
   2. Member has had an inadequate response, or contraindication/intolerable side effects to, at least TWO preferred formulary atypical antipsychotics
I. Requests for 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.

1. Meets the criteria common to all covered uses of antipsychotics as noted at the beginning of this section.
   AND
2. Has chart documented evidence of a comprehensive clinical evaluation of conditions; including
3. Treatment plan that comprehensively addresses of all behaviors and conditions;
4. The use of more established medications to treat underlying/comorbid conditions as applicable.
5. 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.

**For members greater than 18 years old requesting a non-formulary Atypical Antipsychotic:**

**Documentation of ALL of the following:**

A. Antipsychotic is being prescribed by, or in consultation with a psychiatrist
B. Antipsychotic is prescribed within FDA approved daily dosing, treatment guidelines or recognized compendia..
C. Documentation of baseline 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.
D. Additional criteria for Bipolar Disorder or Schizophrenia (ONE of the following):
   a. The Member had treatment failure, contraindication or intolerance on at least TWO preferred formulary atypical antipsychotics; OR
   b. The Member is currently stabilized on the antipsychotic and documentation is provided to support evidence of stabilization within the most recent 90 days.

Last Review: 4/2018
Previous PARP Approval: 6/2017
Current PARP Approval: 6/2018
E. Additional criteria for Major Depressive Disorder:
   a. Documentation of failure or unresponsiveness, contraindication or intolerance to THREE different antidepressants from at least TWO different therapeutic subclasses
   b. Member meets ONE of the following:
      i. The Member had treatment failure, contraindication or intolerance on at least TWO preferred formulary atypical antipsychotics; OR
      ii. The Member is currently stabilized on the antipsychotic and documentation is provided to support evidence of stabilization within the most recent 90 days.

*Trial Dose- First 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 the 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
  - Renewals require documentation of the following:
    ▪ Improvement in target symptoms
    ▪ Treatment plan that contains either plan for discontinuation or rationale for continued use
    ▪ Monitoring for tardive dyskinesia using AIMS or DISCUS at 3mo renewal and annually thereafter.
  - Follow-up metabolic monitoring: weight/BMI/waist circumference every three months AND BP, fasting glucose or A1c, fasting lipids: at baseline and the 3mo renewal, thereafter monitoring should be continued at 6 months, and then annually thereafter.

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 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: