

## Antipsychotic Agents – Antipsychotic Oral Agents (6)

Point-of-Sale (POS) edits are safety limitations that are automatically verified through computer programming at the time that a prescription claim is submitted at the pharmacy. These edits can be applied to *any* medication, whether or not it is listed in the Preferred Drug List / Non-Preferred Drug List (PDL/NPDL). The first section of this document is organized to follow the order of the therapeutic classes in the PDL/NPDL and explains the POS edits for those medications.

### POS Abbreviations

<b>AL</b> – Age Limit	<b>DD</b> – Drug-Drug Interaction	<b>MD</b> – Maximum Dose Limit	<b>TD</b> - Therapeutic Duplication
<b>BH</b> – Behavioral Health Clinical Authorization for Children Younger than <b>76</b> Years of Age	<b>DS</b> Maximum Days’ Supply Allowed	<b>PR</b> – Enrollment in a Physician-Supervised Program Required	<b>UN</b> – Drug Use Not Warranted
<b>BY</b> – Diagnosis Codes Bypass Some Requirements	<b>DT</b> – Duration of Therapy Limit	<b>PU</b> – Prior Use of Other Medication is Required	<b>X</b> – Prescriber Must Have ‘X’ DEA Number
<b>CL</b> – Additional Clinical Information is Required	<b>DX</b> – Diagnosis Code Requirement	<b>QL</b> – Quantity Limit	<b>YQ</b> – Yearly Quantity Limit
<b>CU</b> – Concurrent Use with Other Medication is Restricted	<b>ER</b> – Early Refill	<b>RX</b> – Specific Prescription Requirement	

<b>Pharmacy Prior Authorization Phone Numbers for MCOs and FFS</b>
Aetna Better Health of Louisiana <b>1-855-242-0802</b>
AmeriHealth Caritas Louisiana <b>1-800-684-5502</b>
Fee-for-Service (FFS) Louisiana Legacy Medicaid <b>1-866-730-4357</b>
Healthy Blue <b>1-844-521-6942</b>
Louisiana Healthcare Connections <b>1-888-929-3790</b>
UnitedHealthcare <b>1-800-310-6826</b>

## Antipsychotic Agents – Antipsychotic Oral / Transdermal Agents (96)

### POS Edits

**AL** – Pimavanserin (Nuplazid®) is limited to use in recipients who are at least 18 years old.

**BH** – Additional behavioral-health related clinical information (trial of behavioral therapy, etc.) is required for all agents **EXCEPT** pimavanserin (Nuplazid®) when requested for recipients who are younger than 76 years of age.

**CL** – Additional clinical information is required for pimavanserin (Nuplazid®).

**DX** – Pharmacy claims for all agents must be submitted with an appropriate diagnosis code found at [THIS LINK](#).

**MD** – Some agents have a maximum daily dose as listed in the chart below.

Generic – Brand Example	Age (Years)						
	Younger than 5	5	6-9	10-12	13-15	16-17	18 and older
Aripiprazole – Abilify®	5mg	20mg	20mg	20mg	30mg	30mg	30mg
Aripiprazole – Abilify® MyCite®	0mg	0mg	0mg	0mg	0mg	0mg	30mg
Asenapine – Saphris®	0mg	0mg	0mg	20mg	20mg	20mg	20mg
Asenapine Transdermal - Secuado®	0mg	0mg	0mg	0mg	0mg	0mg	7.6mg
Brexpiprazole – Rexulti®	0mg	0mg	0mg	0mg	0mg	4mg	4mg
Cariprazine – Vraylar®	0mg	0mg	0mg	0mg	0mg	4.5mg	6mg
Vraylar® Therapy Pack	0mg	0mg	0mg	0mg	0mg	4.5mg	6mg
Clozapine – Clozaril®, FazaClo®, Versacloz®	0mg	0mg	0mg	0mg	0mg	0mg	900mg
Iloperidone – Fanapt®	0mg	0mg	0mg	0mg	0mg	16mg	24mg
Lurasidone – Latuda®	0mg	0mg	0mg	80mg	80mg	80mg	160mg
Olanzapine – Zyprexa®	10mg	20mg	20mg	20mg	30mg	30mg	40mg
Olanzapine/Fluoxetine – Symbyax®	0mg	0mg	0mg	12mg/50mg	12mg/50mg	12mg/50mg	18mg/75mg
Paliperidone – Invega®	3mg	6mg	6mg	6mg	9mg	9mg	12mg
Quetiapine – Seroquel®	100mg	600mg	600mg	600mg	1000mg	1000mg	1200mg
Risperidone – Risperdal®	3mg	6mg	6mg	6mg	8mg	8mg	16mg
Ziprasidone – Geodon®	30mg	60mg	60mg	60mg	120mg	120mg	200mg

**PU** – The pharmacy POS system will verify the following:

- For pharmacy claims for cariprazine (Vraylar®) – previous claims for at least a 90 day supply of cariprazine **OR** ~~previous claims for at least a 90 day supply of a preferred generic oral antipsychotic within the previous 90 days~~
- For pharmacy claims for lurasidone (Latuda®) - previous claims for at least a 90 day supply of lurasidone **OR** ~~previous claims for at least a 90 day supply of a preferred generic oral antipsychotic within the previous 90 days~~

## Antipsychotic Agents – Antipsychotic ~~Oral~~ Oral / Transdermal Agents (96)

### POS Edits

**TD** – Oral and transdermal antipsychotic agents are monitored at the pharmacy POS for duplication of therapy with other oral or transdermal antipsychotic agents.

<p><b>QL</b> – Selected agents have quantity limits as listed in the <a href="#">chart to the right</a>.</p>	<b><u>Quantity Limits for Selected Antipsychotic Oral Agents</u></b>	
	<b><u>Medication</u></b>	<b><u>Medication</u></b>
	<a href="#">Nuplazid™ 17mg</a>	<a href="#">Nuplazid™ 17mg</a>
	<a href="#">Nuplazid™ 34 mg</a>	<a href="#">Nuplazid™ 34 mg</a>
	<a href="#">Secuado®</a>	<a href="#">Secuado®</a>
	<a href="#">Vraylar® Therapy Pack</a>	<a href="#">Vraylar® Therapy Pack</a>

Revision	Date
Created POS Document	February 2020
Added Secuado®, formatting changes	July 2020
<a href="#">Modified to apply new age requirement for behavioral health clinical authorization</a>	<a href="#">September 2020</a>
<a href="#">Added previous use information for cariprazine (Vraylar®) and lurasidone (Latuda®)</a>	<a href="#">November 2020</a>