Louisiana Medicaid
Antipsychotics

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request:

- Clinical authorization for pimavanserin (Nuplazid®); **OR**
- ~~Authorization for non-preferred agents for recipients 6 years of age and older; **AND**~~
- Behavioral Health clinical ~~A~~authorization for *all* preferred and non-preferred agents *for recipients younger than 6 years of age*; ~~**AND**~~**OR**
- Prior authorization for non-preferred agents for recipients 6 years of age and older; **OR**
-
- Authorization to ~~exceed~~ override the maximum daily dose/quantity limit for all ages~~.~~
- ~~Clinical authorization for pimavanserin (Nuplazid®)~~

Additional Point-of-Sale edits may apply.

*Some ~~of these~~ agents have **Black Box Warnings**, and/or are subject to **Risk Evaluation and Mitigation Strategy (REMS)**, under FDA safety regulations. Please refer to individual prescribing information for details.*

Pimavanserin (Nuplazid®)

Approval Criteria ~~for Initial Requests for Pimavanserin~~

- The ~~R~~recipient is 18 years of age or older on date of request; **AND**
- The ~~R~~recipient has a diagnosis of hallucinations and/or delusions associated with Parkinson's disease psychosis (Nuplazid® is not approved for the treatment of patients with dementia-related psychosis unrelated to the hallucinations and delusions associated with Parkinson's disease psychosis~~.~~); **AND**
- Previous use of a preferred product - **ONE** of the following is required:
  - ~~**ONE** of the following applies:~~
  - There has been ~~recipient has had~~ a treatment failure or intolerable side effect with or contraindication to ~~with~~ a preferred product; ~~antipsychotic medication that is appropriate to use for treatment of the diagnosis;~~ **OR**
  - There is no preferred product ~~Clinical justification as to why a preferred ap~~appropriate ~~treatment~~ to use for the condition being treated~~option cannot be used must be provided~~; **AND**
- By submitting the authorization request, the prescriber attests to the following:
  - The recipient has been assessed for risk factors for prolonged QT interval; **AND**
  - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
  - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed as of the date of the request and will be repeated as recommended; **AND**
  - The recipient has no ~~inappropriate~~ concomitant drug therapies or disease states that limit the use of the requested medication; **AND**
  - ~~o~~ The prescriber is aware that this medication should be used with caution in severe renal impairment (CrCl less than 30ml/minute) and end stage renal disease.
  - ~~Diagnosis code: G20~~

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Reauthorization ~~criteria~~Criteria

- The recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that there is evidence of a positive response to therapy ~~as indicated by improvement in signs and symptoms compared to baseline~~.

~~*~~Duration of ~~initial~~ Initial and ~~reauthorization~~ Reauthorization ~~approval~~Approval: 12 months~~***~~**

Approval Criteria for *ALL* Agents (Preferred and Non-Preferred) for Recipients Under 6 Years of Age~~:~~

- For a non-preferred agent, previous use of a preferred product - **ONE** of the following is required ~~the following conditions apply~~:
  - There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
  - The recipient has had *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has ~~a~~ *documented contraindication(s)* to all of the preferred products that are appropriate for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
  - The recipient is established on the medication with positive clinical outcomes; **AND**
- The requested medication has been prescribed for an approved diagnosis (~~See Table 1~~see POS Edits); **AND**
- ~~By submitting the authorization request, the prescriber attests to the following:~~
  - ~~The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**~~
  - ~~All laboratory testing and clinical monitoring recommended in the prescribing information have been completed (as of the date of the request) at baseline, every six months, and with dosage changes, and will be repeated as recommended in the prescribing information; **AND**~~
  - ~~The recipient has no inappropriate concomitant drug therapies or disease states; **AND**~~
- By submitting the authorization request, the prescriber attests to the fact that a systematic evaluation and assessment have been performed which includes but is not limited to, the following:
  - Detailed history of symptoms (including symptoms from non-custodial caregivers); **AND**
  - Medical, substance use, developmental, and social factors that may influence clinical presentation have been addressed; **AND**
  - Documentation of in-office observations (including appointment dates) which support recorded behavior / symptoms; **AND**
  - Documentation of impairing, extreme symptoms of aggression towards self and/or others; **AND**~~.~~
- By submitting the authorization request, the prescriber attests to the following:
  - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**

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- All laboratory testing and clinical monitoring recommended in the prescribing information have been completed (as of the date of the request) at baseline, every six months, and with dosage changes, and will be repeated as recommended in the prescribing information; **AND**
- The recipient has no ~~inappropriate~~ concomitant drug therapies or disease states that limit the use of the requested medication~~; **AND**~~**.**

Reauthorization Criteria

- The recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that there is evidence of a positive response to therapy.

~~-~~ ~~*****Duration of Initial and Reauthorization Approval: 12 months or up to the recipients 6th birthday, whichever is less.**~~

~~*******~~

Approval Criteria for Non-Preferred Agents for Recipients 6 years of Age and Older:

- The requested medication has been prescribed for an approved diagnosis (see POS Edits ~~See Table 1~~); **AND**
- ~~By submitting the authorization request, the prescriber attests to the following:~~
  - ~~The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**~~
  - ~~All laboratory testing and clinical monitoring recommended in the prescribing information have been completed (as of the date of the request) at baseline, every six months, and with dosage changes, and will be repeated as recommended in the prescribing information; **AND**~~
  - ~~The recipient has no inappropriate concomitant drug therapies or disease states; **AND**~~
- Previous use of a preferred product - **ONE** of the following is required~~The following conditions apply~~:
  - There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
  - The recipient has had *treatment failure* with at least one preferred product; **OR**
  - The recipient has had an *intolerable side effect* to at least one preferred product; **OR**
  - The recipient has ~~a~~ *documented contraindication(s)* to all of the preferred products that are appropriate for the condition being treated; **OR**
  - There is *no preferred product that is appropriate* to use for the condition being treated; **OR**
  - The recipient is established on the medication with positive clinical outcomes; **AND**~~.~~
- By submitting the authorization request, the prescriber attests to the following:
  - The prescribing information for the requested medication has been thoroughly reviewed, including any Black Box Warning, Risk Evaluation and Mitigation Strategy (REMS), contraindications, minimum age requirements, recommended dosing, and prior treatment requirements; **AND**
  - All laboratory testing and clinical monitoring recommended in the prescribing information have been completed (as of the date of the request) at baseline, every six months, and with dosage changes, and will be repeated as recommended in the prescribing information; **AND**
  - The recipient has no ~~inappropriate~~ concomitant drug therapies or disease states that limit the use of the requested medication~~; **AND**~~**.**

Reauthorization Criteria

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- The recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that there is evidence of a positive response to therapy.

*****Duration of Initial and Reauthorization Approval: 12 months*****

Approval ~~criteria~~ Criteria for ~~all~~ All ~~ages~~ Ages to ~~override~~ Override ~~maximum~~ Maximum ~~daily~~ Daily ~~dose~~ Dose and/or ~~quantity~~ Quantity ~~limits~~Limits:

- The requested medication has been prescribed for an approved diagnosis (~~See Table 1~~see POS Edits); **AND**
- One of the following conditions apply:
  - The recipient has been treated in the past or is currently receiving treatment with the requested dosage and quantity of the requested medication with a lack of objective adverse effects (such as weight) and subjective adverse effects (by patient report); **OR**
  - The recipient had a partial but inadequate response to the requested medication at a lower dosage/quantity available under the plan **AND ALL** of the following:
    - Medication non-adherence was ruled out as a reason for the inadequate response; **AND**
    - The recipient tolerated the medication at the lower dosage; **AND**
    - There was a lack of objective adverse effects (such as weight) and subjective adverse effects (by patient report); **AND**
    - The requested dose is considered medically necessary; **OR**
  - The recipient has not previously used this medication; however, the prescriber is submitting evidence supporting quantity limit exception with this request (for example, a peer-reviewed journal article demonstrating the safety and efficacy of the requested dose for the indication); **AND ALL** of the following:
    - The requested quantity and dosing are supported in the accepted medical compendia; **AND**
    - The requested dose is considered medically necessary.

~~Renewal~~ Reauthorization criteria

- The recipient continues to meet initial approval criteria; **AND**
- The prescriber **states on the request** that there is evidence of a positive response to therapy.
- ~~The prescriber states that the recipient is established on the requested medication with evidence of a positive response to therapy.~~

*****Duration of ~~initial~~ Initial and ~~reauthorization~~ Reauthorization ~~approval~~Approval: ~~-~~12 months*****

~~**NOTE:** Diagnosis code requirements apply to both preferred and non-preferred agents (see Table 1).~~

~~Aripiprazole Oral - Abilify®¥~~	~~Aripiprazole Injection Suspension - Abilify Maintena® Injection~~
~~Aripiprazole Lauroxil ER Injection Suspension - Aristada® Injection, Aristada® Initio™~~	~~Asenapine - Saphris®~~
~~Brexpiprazole - Rexulti®¥~~	~~Cariprazine - Vraylar®~~
~~Chlorpromazine Oral, Injection~~	

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~~Clozapine - Clozaril®, FazaClo®, Versacloz®~~ ~~Fluphenazine Oral, Injection, Decanoate . . Injection~~
~~Haloperidol Oral, Decanoate & Lactate . Injection - Haldol®~~ ~~Iloperidone - Fanapt®, Fanapt® Titration Pack~~
~~Loxapine, Breath-Activated Aerosol Powder - . . Adasuve®~~ ~~Loxapine, Capsule~~
~~Lurasidone - Latuda®~~ ~~Olanzapine Oral and Injection - Zyprexa®~~
~~Olanzapine Injection Suspension - . Zyprexa Relprevv™~~ ~~Paliperidone Oral - Invega®~~
~~Paliperidone Injection (1-month) - . Invega Sustenna®~~ ~~Paliperidone Injection (3-month) - . Invega Trinza®~~
~~Perphenazine~~ ~~Prochlorperazine Oral and Injection - . Compazine®~~
~~Quetiapine - Seroquel®~~ ~~Quetiapine XR - Seroquel XR®¥~~ ~~Risperidone Oral - Risperdal®~~
~~Risperidone Injection Suspension - . Risperdal Consta®, Perseris™~~ ~~Thioridazine~~
~~Thiothixene~~ ~~Trifluoperazine~~
~~Ziprasidone Oral and Injection - Geodon®~~

~~Olanzapine/Fluoxetine - Symbyax®†~~

~~Perphenazine/Amitriptyline‡~~

~~‡ Aggr~~
~~Develo~~
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~~Bipola~~
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Aripiprazole Or Olanzapine Oral - Zyprexa® Quetiapine - Seroquel® Quetiapine XR - Seroquel XR® Risperidone Oral - Risperdal® Ziprasidone Oral - Geodon®	Schizo Disord Agitati Schizo † Nega or Schi ‡ Schi Schizo Depres
Aripiprazole Or Haloperidol Oral & Lactate Injection - . Haldol® Pimozide - Orap® Quetiapine - Seroquel® Quetiapine XR - Seroquel XR® Risperidone Oral - Risperdal® Risperidone Injection Suspension - . Risperdal Consta®	Disrup Person Disord Disord Pervas Unsoci Additi Person Disord Disord Tics/T
Chlorpromazine Oral, Injection	Hiccou Nausea Porphy Tetanu
Chlorpromazine Oral and Injection Haloperidol Oral - Haldol®	Attenti Severe
Perphenazine Prochlorperazine Oral, Injection and . Rectal - Compazine®	Severe

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Olanzapine/Fluoxetine - Symbyax® Perphenazine/Amitriptyline	Depres
Perphenazine/Amitriptyline Prochlorperazine Oral - Compazine® Trifluoperazine	Anxiet
Pimavanserin (Nuplazid™)§	Halluc Associ Psych
Aripiprazole Tablet with Sensor (Abilify® MyCite®)	Bipola
	Major
	Schizo Disord

* Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned

‡ Diagnosis description is specific for olanzapine/fluoxetine (Symbyax®).
‡ Diagnosis description is specific for perphenazine/amitriptyline.
¥ Diagnosis description is specific for aripiprazole oral (Abilify®), brexpiprazole (Rexulti®), and quetiapine XR (Seroquel XR®).
§ See pimavanserin (Nuplazid™) authorization document for specific criteria.

Please note: If recipient's diagnosis code is not included in this list, the prescribin

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Revision	Date
Single PDL Implementation	May 2019
Added POS wording, added Abilify MyCite to diagnosis and maximum daily dose charts, updated quantity limit chart	June 2019
Removed medication tables, modified remaining table numbers and references to tables, removed POS wording, added override wording under maximum daily dose chart, added peer-reviewed literature reference.	November 2019
Removed Fee-for-Service, modified format, removed footer, added revision table, combined antipsychotics criteria and pimavanserin criteria into one document	January 2020
Removed POS edits, added Secuado reference, formatting changes	July 2020

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