Antipsychotic Agents – Antipsychotic Oral / Transdermal Agents

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

AL – Age Limit	**DD** – Drug-Drug Interaction	**MD** – Maximum Dose Limit	**TD** - Therapeutic Duplication
BH – Behavioral Health Clinical Authorization for Children Younger than 7 Years of Age	**DS** Maximum Days' Supply Allowed	**PR** – Enrollment in a Physician-Supervised Program Required	**UN** – Drug Use Not Warranted
BY – Diagnosis Codes Bypass Some Requirements	**DT** – Duration of Therapy Limit	**PU** – Prior Use of Other Medication is Required	**X** – Prescriber Must Have 'X' DEA Number
CL – Additional Clinical Information is Required	**DX** – Diagnosis Code Requirement	**QL** – Quantity Limit	**YQ** – Yearly Quantity Limit
CU – Concurrent Use with Other Medication is Restricted	**ER** – Early Refill	**RX** – Specific Prescription Requirement	

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

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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 7 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
Lumateperone – Caplyta®	0mg	0mg	0mg	0mg	0mg	0mg	42mg
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

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<table>
<tr><th colspan="3">POS Edits</th></tr>
<tr><td colspan="3">*Maximum daily dose applies to all oral/transdermal formulations of these agents.</td></tr>
<tr><td colspan="3">PU – The pharmacy POS system will verify the following:
For pharmacy claims for cariprazine (Vraylar®) – previous claim for cariprazine OR a preferred generic oral antipsychotic within the previous 365 days
For pharmacy claims for lurasidone (Latuda®) – previous claim for lurasidone OR a preferred generic oral antipsychotic within the previous 365 days</td></tr>
<tr><td colspan="3">TD – Oral and transdermal antipsychotic agents are monitored at the pharmacy POS for duplication of therapy with other oral or transdermal antipsychotic agents.</td></tr>
<tr><td rowspan="6">QL – Selected agents have quantity limits as listed in the chart to the right.</td><td colspan="2">Quantity Limits for Selected Antipsychotic Oral Agents</td></tr>
<tr><td>Medication</td><td>Quantity Limit</td></tr>
<tr><td>Lybalvi™</td><td>30 tablets per 30 days</td></tr>
<tr><td>Nuplazid® 10mg</td><td>30 tablets per 30 days</td></tr>
<tr><td>Nuplazid® 34 mg</td><td>30 capsules per 30 days</td></tr>
<tr><td>Secuado®</td><td>30 patches per 30 days</td></tr>
<tr><td>Vraylar® Therapy Pack</td><td>1 pack per 18-month period</td></tr>
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Revision / Date	Implementation Date
Created POS Document	February 2020
Added Secuado®, formatting changes / February 2020	May 2020
Modified to apply new age requirement for behavioral health clinical authorization / September 2020	January 2021
Added previous use information for cariprazine (Vraylar®) and lurasidone (Latuda®) / November 2020	January 2021
Changed previous use requirement for cariprazine (Vraylar®) and lurasidone (Latuda®) from 90 days to 365 days / April 2021	April 2021
Added Lybalvi™, added MD for lumateperone (Caplyta®), and added QL for Nuplazid® 10mg tablet / October 2021	April 2022