

## 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

<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 7 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	

#### 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. Requests to override the maximum dose limit should follow THIS CRITERIA.

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
Brexipiprazole – Rexulti®	0mg	0mg	0mg	0mg	<del>40</del> mg	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

\*Maximum daily dose applies to all oral/transdermal formulations of these agents.

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### POS Edits

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

<b>QL</b> – Selected agents have quantity limits as listed in the chart to the right.	Quantity Limits for Selected Antipsychotic Oral Agents	
	Medication	Quantity Limit
	<u>Latuda® 20mg/, 40mg/, 60mg/ &amp; 120mg</u>	<u>30 tablets per 30 days</u>
	<u>Latuda® 80mg</u>	<u>60 tablets per 30 days</u>
	Lybalvi™	30 tablets per 30 days
	Nuplazid® 10mg	30 tablets per 30 days
	Nuplazid® 34mg	30 capsules per 30 days
	Secuado®	30 patches per 30 days
	Vraylar® Therapy Pack	1 pack per 18-month period

## Antipsychotic Agents – Antipsychotic Oral / Transdermal Agents

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
<u>Modified Rexulti® MD for 13-15 years old, added QL for Latuda®, formatting changes / February 2022</u>	<u>July 2022</u>