Louisiana Medicaid
Antipsychotics

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

- Behavioral Health clinical authorization for *all* preferred and non-preferred agents *for recipients younger than 7 years of age*; **OR**
- EXTENDED prior authorization for non-preferred agents (EXCEPT Abilify Mycite®) for recipients 21 years of age or older with specified diagnoses who meet specified criteria; **OR**
- TRADITIONAL prior authorization for non-preferred agents for recipients 7 years of age and older who do not meet specified criteria for EXTENDED prior authorization; **OR**
- Clinical authorization for pimavanserin (Nuplazid®)

Additional Point-of-Sale edits may apply.

*These agents may 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.*

Each plan has an allowance for a 72-hour supply of the requested medication while the prior authorization is being reviewed.

Approval Criteria for *ALL* Agents (Preferred and Non-Preferred) for Recipients Under 7 Years of Age

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- For a non-preferred agent, previous use of a preferred product - **ONE** of the following is required:
    - 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 *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 POS Edits); **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**
    - 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 concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Reauthorization Criteria

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

Duration of initial and reauthorization approval: 12 months <u>or</u> up to the recipient's 7th birthday, whichever is less.

Approval Criteria for EXTENDED Authorization or TRADITIONAL Authorization for Non-Preferred Agents for Recipients 7 years of Age and Older

EXTENDED Authorization (EXCEPT Abilify Mycite®)

- The recipient is 21 years of age or older on the date of the request; **AND**
- The recipient has one of the following diagnoses:
    - Schizophrenia, schizotypal disorder, or schizoaffective disorder (F20*, F21, or F25*); **OR**
    - Delusional disorders (F22); **OR**
    - Psychotic disorders (F06.0, F23, F28, F29, F30.2, F31.2, F31.5, F31.64, F32.3, F33.3); **AND**
- **ONE** of the following:
    - The recipient has failed treatment with a preferred agent; **OR**
    - The recipient is established on the requested medication.

If the recipient meets the criteria for an EXTENDED authorization, duration of approval: Lifetime – with an end date of 12/31/2050

If recipient does NOT meet criteria for EXTENDED authorization, use TRADITIONAL authorization criteria.

TRADITIONAL Authorization

- There is no preferred alternative that is the exact same chemical entity, formulation, strength, etc.; **AND**
- Previous use of a preferred product - **ONE** of the following is required:
    - 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 *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 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 concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling.

Reauthorization Criteria

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

Duration of TRADITIONAL initial and reauthorization approval for Abilify MyCite®: 3 months
Duration of TRADITIONAL initial and reauthorization approval for all other non-preferred antipsychotic agents: 12 months

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Pimavanserin (Nuplazid®)

Approval Criteria

- The recipient is 18 years of age or older on date of request; **AND**
- The 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:

    - There has been a treatment failure or intolerable side effect with or contraindication to a preferred product; **OR**
    - There is no preferred product appropriate to use for the condition being treated; **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 concomitant drug therapies or disease states that limit the use of the requested medication and will not be receiving the requested medication in combination with any other medication that is contraindicated or not recommended per FDA labeling; **AND**
    - 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.

Reauthorization Criteria

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

Duration of initial and reauthorization approval: 12 months

References

Gleason, M., Egger, H., Emslie, G., Greenhill, L., Kowatch, R., Lieberman, A., Luby, J., Owens, J., Scahill, L., Scheeringa, M., Stafford, B., Wise, B. and Zeanah, C. (2007). Psychopharmacological Treatment for Very Young Children: Contexts and Guidelines. Journal of the American Academy of Child & Adolescent Psychiatry, 46(12), pp.1532-1572.

Nuplazid (pimavanserin) [package insert]. San Diego, CA: Acadia Pharmaceuticals Inc; November 2020. https://www.nuplazidhcp.com/pdf/NUPLAZID_Prescribing_Information.pdf

Politte LC, McDougle CJ. Atypical antipsychotics in the treatment of children and adolescents with pervasive developmental disorders. Psychopharmacology (Berl). 2014 Mar;231(6):1023-36. doi: 10.1007/s00213-013-3068-y. Epub 2013 Apr 4. PMID: 23552907.

Single PDL Implementation	May 2019
Added POS wording, added Abilify MyCite to diagnosis and maximum daily dose charts, updated quantity limit chart / June 2019	November 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	January 2020
Removed Fee-for-Service, modified format, removed footer, added revision table, combined antipsychotics criteria and pimavanserin criteria into one document / January 2020	January 2020
Removed POS edits, added Secuado® reference, formatting changes / July 2020	July 2020
Added Caplyta™ reference / July 2020	July 2020
Modified to apply new age requirement / September 2020	January 2021
Modified duration of authorization for Abilify MyCite®, formatting changes, updated references / June 2021	January 2022
Added specific wording for use of Saphris® / October 2021	January 2022
Removed override criteria wording, removed wording for use of Saphris® / February 2022	July 2022
Added wording for EXTENDED authorization / June 2022	August 2022