Atypical Antipsychotics Step Therapy with Quantity Limit

STEP THERAPY CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval

Target Agent(s)	Prerequisite Agents
Abilify (aripiprazole)*	Any generic atypical antipsychotic Any generic antidepressant (i.e., SSRI, SNRI, bupropion, mirtazapine, or vilazodone) haloperidol or pimozide
Abilify Mycite (aripiprazole) **Seroquel XR** (quetiapine)* **Vraylar** (cariprazine)	Any generic atypical antipsychotic Any generic antidepressant (i.e., SSRI, SNRI, bupropion, mirtazapine, or vilazodone)
Zyprexa (olanzapine)* **Zyprexa Zydis** (olanzapine)*	Any generic atypical antipsychotic generic fluoxetine
Caplyta (lumateperone) **Clozapine ODT*** **Clozaril** (clozapine)* **Fanapt** (iloperidone) **Geodon** (ziprasidone)* **Invega** (paliperidone)* **Latuda** (lurasidone)* **Lybalvi** (olanzapine/samidorphan) **Rexulti** (brexpiprazole) **Risperdal** (risperidone)* **Risperidone ODT^/risperidone ODT**	Any generic atypical antipsychotic

Module	Clinical Criteria for Approval

Saphris (asenapine)* **Secuado** (asenapine) **Seroquel** (quetiapine)* **Versacloz** (clozapine)	

*generic available

^branded generic product

PRIOR AUTHORIZATION CRITERIA FOR APPROVAL

Target Agent(s) will be approved when ONE of the following is met:

1. The request is for Abilify **AND** ONE of the following:
   A. The patient has a medication history of use in the past 365 days, intolerance, or hypersensitivity to ONE generic antidepressant agent (i.e., SSRI, SNRI, bupropion, mirtazapine, or vilazodone), generic haloperidol or pimozide **OR**
   B. The patient has an FDA labeled contraindication to ALL generic antidepressant agents (i.e., SSRI, SNRI, bupropion, mirtazapine, or vilazodone), haloperidol and pimozide **OR**
2. The request is for Abilify Mycite, Rexulti, Seroquel XR, or Vraylar **AND** ONE of the following:
   A. The patient has a medication history of use in the past 365 days, intolerance, or hypersensitivity to ONE generic antidepressant agent (i.e., SSRI, SNRI, bupropion, mirtazapine, or vilazodone) **OR**
   B. The patient has an FDA labeled contraindication to ALL generic antidepressants (i.e., SSRI, SNRI, bupropion, mirtazapine, or vilazodone) **OR**
3. The request is for Zyprexa or Zyprexa Zydis **AND** ONE of the following:
   A. The patient has a medication history of use in the past 365 days, intolerance, or hypersensitivity to ONE generic fluoxetine **OR**
   B. The patient has an FDA labeled contraindication to ALL generic fluoxetine **OR**
4. Information has been provided that indicates the patient has been treated with the requested agent within the past 180 days **OR**
5. The prescriber states the patient is has been treated with the requested agent within the past 180 days AND is at risk if therapy is changed **OR**
6. The patient has a medication history of use in the past 365 days, intolerance, or hypersensitivity to ONE generic atypical antipsychotic **OR**
7. The patient has an FDA labeled contraindication to ALL generic atypical antipsychotics

Length of Approval: For dementia-related psychosis: 3 months for initial approval; 6 months for renewals

For all other indications: 12 months

NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: A. BOTH of the following: 1. The requested agent does not have a maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support therapy with a higher dose for the requested indication **OR** B. BOTH of the following: 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit **OR** C. BOTH of the following: 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support therapy with a higher dose for the requested indication **Length of Approval**: up to 12 months