Louisiana Medicaid
Antipsychotics

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

- Authorization for non-preferred agents for recipients 6 years of age and older; **AND**
- Authorization for all preferred and non-preferred agents for recipients younger than 6 years of age; **AND**
- Authorization to exceed maximum daily dose/quantity limit for all ages.

*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®) has criteria separate from Antipsychotics criteria. Please refer to the Nuplazid® criteria document.

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

- For a non-preferred agent, 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 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); **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.

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 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**
- 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 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.

Approval criteria for all ages to override maximum daily dose and/or quantity limits:

- The requested medication has been prescribed for an approved diagnosis (See Table 1); **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 criteria

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

Duration of Authorization Approval:
Initial Approval: 12 months
Reauthorization Approval: 12 months

NOTE: Diagnosis code requirements apply to both preferred and non-preferred agents (see Table 1). Maximum daily dose edits (see Table 2), quantity limits (see Table 3), and other requirements at Point-of-Sale for select agents in this category may apply to both preferred and non-preferred agents. For additional information, see http://www.lamedicaid.com/provweb1/Pharmacy/pharmacyindex.htm.

Table 1. Approved ICD-10-CM Diagnosis Codes for Antipsychotic Medications		
Generic - Brand Examples	**Diagnosis Description**	**ICD-10 Codes**
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 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‡	Agitation or Aggression or Irritability in Pervasive Developmental Disorder (PDD)/Autistic Disorder † Negative Symptoms of Pervasive Developmental Disorder (PDD) ‡ Aggression or Irritability in Pervasive Developmental Disorder (PDD) with Depression	F84.*
	Bipolar Disorder, Agitation or Psychoses in Bipolar Disorder, Agitation or Psychoses in Other Episodic Mood Disorders † Bipolar Depression, Negative Symptoms of Psychoses in Bipolar Disorder, Negative Symptoms of Psychoses in Other Episodic Mood Disorders ‡ Bipolar Disorder with Depression, Other Episodic Mood Disorders with Depression	F30.*, F31.*, F32.8, F34.8, F34.9, F39
	Delusions, Dementia, Psychoses or Agitation in Delusions, Dementia, Psychoses † Negative Symptoms of Delusions, Dementia or Psychoses ‡ Delusions with Depression, Dementia with Depression, Psychoses with Depression	F01.*, F02.*, F03.*, F04, F05, F06.0, F06.2, F06.30, F06.31, F06.32, F06.33, F06.34, F06.8, F10.150, F10.151, F10.250, F10.251, F10.26, F10.94, F10.950, F10.951, F10.96, F10.97, F11.121, F11.150, F11.151, F11.221, F11.250, F11.251, F11.921, F11.950, F11.951, F12.121, F12.150, F12.151, F12.221, F12.250, F12.251, F12.921, F12.950, F12.951, F13.121, F13.150, F13.151, F13.221, F13.250, F13.251, F13.27, F13.921, F13.950, F13.951, F13.97, F14.121, F14.150, F14.151, F14.221, F14.250, F14.251, F14.921, F14.950, F14.951, F15.121, F15.150, F15.151, F15.221, F15.250, F15.251, F15.921, F15.950, F15.951, F16.121, F16.150, F16.151, F16.221, F16.250, F16.251, F16.921, F16.950, F16.951, F18.121, F18.150, F18.151, F18.17, F18.221, F18.250, F18.251, F18.27, F18.921, F18.950, F18.951, F18.97, F19.121, F19.150, F19.151, F19.17, F19.221, F19.250, F19.251, F19.27, F19.921, F19.950, F19.951, F19.97, F22, F23, F24, F28, F29, F32.3, F33.3, F44.89
	Agitation or Psychoses in Major Depressive Disorder † Major Depressive Disorder, Negative Symptoms of Psychoses in Major Depressive Disorder ¥Major Depressive Disorder	F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9
	Schizophrenia or Schizoaffective Disorder or Agitation in Schizophrenia or Schizoaffective Disorder † Negative Symptoms of Schizophrenia or Schizoaffective Disorder ‡ Schizophrenia with Depression, Schizoaffective Disorder with Depression	F20.*, F25.*

Table 1. Approved ICD-10-CM Diagnosis Codes for Antipsychotic Medications (continued)		
Generic - Brand Examples	**Diagnosis Description**	**ICD-10 Codes**
Aripiprazole Oral - Abilify® Olanzapine Oral - Zyprexa® Quetiapine - Seroquel® Quetiapine XR - Seroquel XR® Risperidone Oral - Risperdal® Ziprasidone Oral - Geodon®	Aggression in Conduct Disorder, Disruptive Behavior Disorder, Explosive Personality Disorder, Impulse Control Disorder, Intermittent Explosive Disorder, Isolated Explosive Disorder, Pervasive Developmental Disorder, or Unsocialized Aggression	F60.3, F63.3, F63.8*, F63.9, F84.*, F91.1, F91.8, F91.9
	Additional Covered Codes: Borderline Personality Disorder, Depersonalization Disorder, Obsessive-Compulsive Disorder, Paranoid Personality Disorder	F42, F48.1, F60.0, F60.3
Aripiprazole Oral - Abilify® Haloperidol Oral & Lactate Injection - Haldol® Pimozide - Orap® Quetiapine - Seroquel® Quetiapine XR - Seroquel XR® Risperidone Oral - Risperdal® Risperidone Injection Suspension - Risperdal Consta®	Tics/Tourette's Disorder	F95.*, G25.6*
Chlorpromazine Oral, Injection	Hiccough	R06.6
	Nausea and Vomiting	G43.A0, K91.0, R11.*
	Porphyria	E80.0, E80.1, E80.20, E80.21, E80.29
	Tetanus	A35
Chlorpromazine Oral and Injection Haloperidol Oral - Haldol®	Attention Deficit Hyperactivity Disorder	F90.*
	Severe Behavioral Problems	F43.24, F63.81, F91.1, F91.8, F91.9
Perphenazine Prochlorperazine Oral, Injection and Rectal - Compazine®	Severe Nausea and Vomiting	G43.A0, K91.0, R11.*
Olanzapine/Fluoxetine - Symbyax® Perphenazine/Amitriptyline	Depression	F31.3*, F31.4, F31.5, F31.75, F31.76, F31.81, F31.9, F32.*, F33.*, F34.1
Perphenazine/Amitriptyline Prochlorperazine Oral - Compazine® Trifluoperazine	Anxiety	F06.4, F34.1, F41.*
Pimavanserin (Nuplazid™)§	Hallucinations and/or Delusions Associated with Parkinson's Disease Psychosis	G20
Aripiprazole Tablet with Sensor (Abilify® MyCite®)	Bipolar Disorder	F30.*, F31.*, F32.8, F34.8, F34.9, F39
	Major Depressive Disorder	F32.0, F32.1, F32.2, F32.3, F32.4, F32.5, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.42, F33.8, F33.9
	Schizophrenia or Schizoaffective Disorder	F20.*, F25.*

* Any number or letter or combination of **UP TO FOUR** numbers and letters of an assigned ICD-10-CM diagnosis code

† 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 prescribing provider may call the appropriate MCO / FFS plan for guidance.

Table 2. Maximum Daily Dose for Select Agents by Age*							
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 with Sensor – Abilify® MyCite®	0mg	0mg	0mg	0mg	0mg	0mg	30mg
Asenapine – Saphris®	0mg	0mg	0mg	20mg	20mg	20mg	20mg
Brexpiprazole – Rexulti®	0mg	0mg	0mg	0mg	0mg	4mg	4mg
Cariprazine – Vraylar®; Vraylar® Therapy Pack	0mg	0mg	0mg	0mg	0mg	4.5mg	6mg
	0mg – only emergency override available for pack						
Clozapine – Clozaril®, FazaClo®, Versacloz®	0mg	0mg	0mg	0mg	0mg	0mg	900mg
Iloperidone – Fanapt®; Fanapt® Titration Pack	0mg	0mg	0mg	0mg	0mg	16mg	24mg
Lurasidone – Latuda®	0mg	0mg	0mg	80mg	80mg	80mg	160mg
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
Long-Acting Injectables – Maximum Recommended Dose for Adults (18 Years of Age or Older)							
Aristada®	0mg	0mg	0mg	0mg	0mg	0mg	1064mg
Invega Trinza®	0mg	0mg	0mg	0mg	0mg	0mg	819mg
Perseris™	0mg	0mg	0mg	0mg	0mg	0mg	120mg

*Authorization is required to exceed these maximum doses. Point-of-Sale (POS) override available for adults (18 years old and older) with prescriber approval.

Table 3. Quantity Limits for Select Agents*	
Medication	**Quantity Limit**
Abilify Maintena®	1 unit every 28 days
Aristada® 441mg syringe	1 unit every 28 days
Aristada® 662mg syringe	1 unit every 28 days
Aristada® 882mg syringe	1 unit every 28 days
Aristada® 1064mg syringe	1 unit every 56 days
Aristada® Initio™ 675mg syringe	Limited to 1 unit per 18-month period
Invega Sustenna®	1 unit every 28 days
Invega Trinza®	1 unit per rolling 90 days
Nuplazid™§ 17mg	60 tablets every 30 days
Nuplazid™§ 34 mg	30 capsules every 30 days
Perseris™	1 unit every 28 days
Risperdal Consta®	2 units every 28 days
Vraylar® Therapy Pack	Limited to 1 pack per 18-month period
Zyprexa Relprevv® 210mg & 300mg	2 units every 28 days
Zyprexa Relprevv® 405mg	1 unit every 28 days

*Authorization is required to exceed these quantity limits.
§ See pimavanserin (Nuplazid™) authorization document for specific criteria.

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Revision	**Date**
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.	November 2019