PHARMACY PRE-AUTHORIZATION CRITERIA

DRUG (S)	**Atypical Antipsychotics** **Abilify MyCite (aripiprazole)** **Fanapt (iloperidone)** **Latuda (lurasidone)** **Saphris (asenapine)** **Vraylar (cariprazine)**
POLICY #	**11101**
INDICATIONS	The Atypical antipsychotics are indicated for many different psychiatric diagnoses, including, but not limited to: 1. Bipolar Disorder 2. Schizophrenia 3. Irritability associated with autistic disorder 4. Psychotic Disorders
CRITERIA	ConnectiCare considers **Fanapt, Latuda, Saphris and Vraylar** to be medically necessary in patients who meet the following criteria: • Patient has had an intolerance to, or treatment failure of, **two** of the following 5 generic atypical antipsychotics (quetiapine, ziprasidone, risperidone, olanzapine, paliperidone or clozapine) **OR** • Previous use of **Fanapt, Latuda, Saphris or Vraylar**, at any time in the past with success and discontinued use, may receive authorization to restart the agent used in the past. For example, a patient who has used Saphris in the past and discontinued its use may receive authorization for coverage of Saphris. Connecticare considers **Latuda** to be medical necessary **for the treatment of bipolar depression** in patients who meet the following criteria: • Patient has had an intolerance to, or treatment failure of, Symbyax (olanzapine with fluoxetine) **OR** • Patient has had an intolerance to, or treatment failure of, Seroquel (quetiapine)

PHARMACY PRE-AUTHORIZATION CRITERIA

DRUG (S)	**Atypical Antipsychotics** **#11101**
CRITERIA	ConnectiCare will authorize **Fanapt, Latuda Saphris or Vraylar** when used for an off-label diagnosis if the following criteria have been met: • The member has tried and failed established FDA approved and/or clinical guideline recommended therapy unless contraindicated • The drug is recognized for treatment of the requested indication in one of the standard reference compendia **OR** • In the absence of being listed in compendia, a minimum of at least two articles from major peer-reviewed journals which supports the proposed use for the specific medical condition as safe and effective. ConnectiCare considers **Abilify MyCite** to be medically necessary in patients who meet the following criteria: • Patient has had an intolerance to, or treatment failure of Abilify Maintena Note: ConnectiCare requires prescribers to submit clinical documentation supporting the drug's effectiveness in treating the intended indication.
LIMITATIONS	Based on the maximum daily dose the following quantities will be limited to: Abilify MyCite –30 tablets per month Fanapt -- 60 tablets per month Latuda -- 30 tablets per month Saphris--60 sublingual tablets per month Vraylar -- 30 tablets per month
REFERENCES	Facts & Comparisons Online
P&T REVIEW HISTORY	10/12, 10/13, 10/14, 2/16, 5/16, 2/17, 1/18, 2/19
REVISION RECORD	10/15, 1/16, 4/16, 9/16, 2/17, 2/19