Updated: 06/2018
DMMA Approved: 07/2018

Request for Prior Authorization for Long-acting Atypical Antipsychotics for Adults at Least 18 Years Old
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Long-acting Atypical Antipsychotics for Adults at Least 18 Years Old require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Long-acting Atypical Antipsychotics for Adults at Least 18 Years Old Prior Authorization Criteria:

For all requests for long-acting atypical antipsychotics for adults at least 18 years old, all of the following criteria must be met:

- For ongoing treatment with the same medication, the prescriber indicates the medication is ongoing and the member is stable
- For requests to start a new medication, the following additional criteria must be met:
    - Diagnosis is documented
    - Documentation the member has tolerated a previous trial of the oral dosage form for the atypical antipsychotic requested or on a medication which metabolizes into an active metabolite of requested medication.
    - Documentation of noncompliance with oral antipsychotics resulting in decompensation or rationale indicating why the member requires and injection approach.
    - Documentation of failure to respond to other clinical attempts to enhance medication adherence such as medication education, titration of the dose of antipsychotic medication to reduce side effects, or compliance packaging.
    - For non-preferred agents, the member has had an adequate trial on a preferred injectable agent with the same active ingredient or a clinically submitted reason for not having a trial on a preferred agent.
    - For long-acting injectable agents administered less frequently than a monthly basis, the member has been stabilized on the minimum number of monthly injections with adequate response and patient tolerance (per prescribing information)
    - The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines

Initial Duration of Approval: 12 months

Reauthorization criteria:

- Documentation indicating the patient has clinically benefited from treatment and remained compliant

Reauthorization Duration of approval: 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.