Antipsychotic Medications Age

Override(s)	Approval Duration
Prior Authorization Quantity Limit	1 year

Atypical Antipsychotics		
Medication	**Comment**	**Quantity Limit**
Abilify (aripiprazole) tablets	Non-Preferred	May be subject to quantity limit
Abilify Discmelt (aripiprazole) oral disintegrating tablets	Non-Preferred	
Abilify Mycite (aripiprazole with sensor) tablets	Non-Preferred	
Abilify (aripiprazole) oral solution	N/A	
Abilify Asimtufii (aripiprazole) Extended Release Injectable Suspension	N/A	
Abilify Maintena (aripiprazole) Extended Release Injectable Suspension	N/A	
Abilify (aripiprazole) Solution for Injection	N/A	
Aristada (aripiprazole lauroxil) IM injection	N/A	
Aristada Initio (aripiprazole lauroxil) IM injection	N/A	
Aripiprazole (oral dose forms)	Preferred	
Caplyta (lumateperone) capsules	N/A	
Clozaril (clozapine) tablets	N/A	
Clozapine oral disintegrating tablets	N/A	
Cobenfy (xanomeline and trospium)	Non-Preferred	
Fanapt (iloperidone) tablets	Non-Preferred	
Fanapt (iloperidone) Titration Pack	Non-Preferred	
Geodon (ziprasidone) capsules	Non-Preferred	
Geodon (ziprasidone) IM injection	N/A	
Ziprasidone capsules (oral dose forms)	Preferred	
Invega (paliperidone ER) tablets	Non-Preferred	
Invega Hafyera (paliperidone palmitate) suspension for IM injection	N/A	
Invega Sustenna (paliperidone palmitate) suspension for IM injection	N/A	
Erzofri (paliperidone palmitate) suspension for IM injection	N/A	
Invega TRINZA (paliperidone palmitate) suspension for IM injection	N/A	
Paliperidone ER (oral dose forms)	Non-Preferred** /Preferred	
Latuda tablets	Non-Preferred	
Lurasidone tablets	Preferred	

Lybalvi (olanzapine/samidorphan) tablets	Non-Preferred	May be subject to quantity limit (continued)
Opipza (aripiprazole) oral film	Non-Preferred	
Rexulti (brexpiprazole) tablets	N/A	
Risperdal (risperidone) tablets, oral solution Risperdal M-tabs (risperidone) oral disintegrating tablets Risperdal Consta (risperidone microspheres) Risperidone (oral dose forms) Perseris (risperidone) for Extended-Release Injectable Solution Rykindo (risperidone) for Extended-Release Injectable Suspension	Non-Preferred Non-Preferred N/A Preferred N/A N/A	
Saphris (asenapine)sublingual tablets Asenapine sublingual tablets Secuado (asenapine) patch	Non-Preferred Preferred Non-Preferred	
Seroquel (quetiapine) tablets Quetiapine immediate release (oral dose forms) Seroquel XR (quetiapine fumarate) tablets Quetiapine ER tablets	Non-Preferred Preferred Non-Preferred Preferred	
Symbyax capsules olanzapine and fluoxetine capsules	Non-Preferred Preferred	
Uzedy (risperidone) Extended-Release Injection	N/A	
Vraylar (cariprazine)	N/A	
Versacloz (clozapine) suspension	N/A	
Zyprexa (olanzapine) tablets Zyprexa Zydis (olanzapine) oral disintegrating tablets Zyprexa (olanzapine) IM injection Zyprexa Relprevv (olanzapine) Extended-Release Powder for injection Olanzapine (oral dose forms)	Non-Preferred Non-Preferred N/A N/A Preferred	
Traditional Antipsychotics		
Molindone tablets		
Pimozide tablets		
Perphenazine tablets Perphenazine/amitriptyline tablets		
Stelazine (trifluoperazine) tablets		
Navane (thiothixene) capsules		
Loxapine/Loxitane capsules, Adasuve (loxapine) inhalation		
Prolixin/Permitil (fluphenazine) tablets, elixir, liquid concentrate, injectables including depot formulations		
Haldol (haloperidol) tablets, liquid concentrate, and injection		
Chlorpromazine tablets, liquid concentrate, injectables		

Prochlorperazine oral, suppository, injectable	May be subject to quantity limit (continued)
Thioridazine	

FDA Approved Minimum Age Requirements for Select Antipsychotic Agents*

	6 months	2 years	3 years	5 years	6 years	10 years	12 years	13 years	18 years
Abilify (aripiprazole) oral tablets/solution					X				
Abilify Asimtufii/Maintena (aripiprazole)									X
Abilify Mycite (aripiprazole)									X
Aristada/Initio (aripiprazole lauroxil)									X
Chlorpromazine oral/inj	X								
Caplyta (lumateperone)									X
Clozapine (Clozaril, Versacloz)									X
Cobenfy (xanomeline/trospium)									X
Erzofri (paliperidone)									X
Fanapt (iloperidone)									X
Fluphenazine decanoate inj							X		
Fluphenazine oral/HCL inj									X
Geodon (ziprasidone) oral/inj									X
Haloperidol (oral)			X						
Haloperidol decanoate/lactate inj									X
Igalmi (dexmedetomidine)									X
Invega (paliperidone) oral							X		
Invega (paliperidone) Sustenna/Trinza/Hafyera									X
Latuda (lurasidone)						X			
Lybalvi (olanzapine/samidorphan)									X
Loxapine									X
Molindone							X		
Opipza (aripiprazole) oral film					X				
Perphenazine							X		
Perphenazine/amitriptyline									X
Perseris (risperidone)									X
Pimozide							X		
Prochlorperazine oral/inj		X							
Prochlorperazine suppository									X
Rexulti (brexpiprazole)								X	
Risperdal (risperidone) oral				X					
Risperdal Consta (risperidone)									X
Rykindo (risperidone)									X
Saphris (asenapine)						X			
Secuado (asenapine) patch									X
Seroquel/XR (quetiapine)						X			
Symbyax (olanzapine/ fluoxetine)						X			
Thioridazine		X							
Thiothixene							X		
Trifluoperazine					X				
Uzedy (risperidone)									X

Vraylar (cariprazine)									X
Zyprexa (olanzapine) oral								X	
Zyprexa (olanzapine) IR inj, Zyprexa Relprevv									X

*A drug may have multiple minimum age requirements depending on indication per label; however, only the lowest age requirement is noted in this chart for each drug.

STEP THERAPY APPROVAL CRITERIA

Requests for non-preferred medications may be approved when the following criteria **AND** age limits below are met:

I. Individual has been maintained on a stable dose of the requested medication;

OR

II. Individual has had a trial and inadequate response or intolerance to **one** preferred generic **oral** antipsychotic;

Preferred generic **oral** antipsychotic agents: aripiprazole; asenapine (tablets, all strengths); lurasidone; olanzapine; olanzapine/fluoxetine; paliperidone extended-release; quetiapine immediate-release; quetiapine extended-release; risperidone; ziprasidone

OR

III. Secuado patch may be approved if individual is unable to take oral medications;

OR

IV. The requested agent is Abilify Mycite and the prescriber has provided verification regarding the clinical necessity to track drug ingestion; **AND**

V. Individual is using for one of the following:
   A. Treatment of schizophrenia; **OR**
   B. Acute treatment of bipolar I disorder (manic and mixed episodes) as monotherapy or as an adjunct to lithium or valproate; **OR**
   C. Maintenance treatment of bipolar I disorder as monotherapy or as an adjunct to lithium or valproate; **OR**
   D. Adjunctive treatment of major depressive disorder (MDD) in combination with an antidepressant;

Requests for paliperidone extended-release may be approved when the following criteria **AND age limits below are met:

I. Individual has been maintained on a stable dose of the requested medication;

OR

II. Individual has had a trial and inadequate response or intolerance to generic oral risperidone immediate-release (tablets, ODT, or solution);

OR

III. Paliperidone extended-release may be approved if individual has a diagnosis of schizoaffective disorder;

PRIOR AUTHORIZATION APPROVAL CRITERIA

Initial requests for antipsychotic agents in the pediatric population (age 17 and under) may be approved when the following criteria are met:

I. Individual has been maintained on a stable dose of the requested medication;

OR

II. Prescriber is a Psychiatrist, Neurologist or Developmental/Behavioral Pediatrician; **OR**

III. Prescriber has consulted with a Psychiatrist, Neurologist or Developmental/Behavioral Pediatrician;

OR

IV. Prescriber does not have timely access to a Psychiatrist, Neurologist or Developmental/Behavioral Pediatrician; **AND**

V. The individual meets the following criteria (Note: If all other conditions below are met, allow 3 month supply to provide time to consult with a specialist):

A. Individual is 5 years of age or older;
AND

B. Medication being requested is one of the following:

1. Risperdal (risperidone) oral; **OR**
2. Chlorpromazine oral/injection; **OR**
3. Prochlorperazine oral/injection; **OR**
4. Thioridazine; **OR**
5. Haloperidol oral;

OR

C. Individual is 6 years of age or older;
AND

D. Medication being requested is one of the following:

1. Abilify (aripiprazole) oral – not Abilify Mycite formulation; **OR**
2. Trifluoperazine; **OR**
3. Opipza (aripiprazole) oral film;

OR

E. Individual is 10 years of age or older;
AND

F. Medication being requested is one of the following:

1. Symbyax (olanzapine and fluoxetine); **OR**
2. Seroquel (quetiapine); **OR**
3. Seroquel XR (quetiapine XR); **OR**
4. Saphris (asenapine); **OR**
5. Latuda (lurasidone);

OR

G. Individual is 12 years of age or older;
AND

H. Medication being requested is one of the following:

1. Invega (paliperidone) oral; **OR**
2. Pimozide; **OR**
3. Perphenazine; **OR**

4. Thiothixene; **OR**
5. Fluphenazine decanoate injection; **OR**
6. Molindone;

OR

I. Individual is 13 years of age or older;
AND
J. Medication being requested is one of the following:
1. Zyprexa (olanzapine) oral;
2. Rexulti (brexpiprazole);

AND

VI. Individual has a psychiatric diagnosis that is amenable to treatment with an antipsychotic agent, including, but not limited to the following:
A. Schizophrenia; **OR**
B. Bipolar disorder [Seroquel (quetiapine), Risperdal (risperidone), Zyprexa (olanzapine), Geodon (ziprasidone), Seroquel XR (quetiapine), Abilify/Abilify Mycite (aripiprazole), Saphris (asenapine), Latuda (lurasidone), Vraylar (cariprazine), Caplyta (lumateperone), Lybalvi (olanzapine/samidorphan), Fanapt (iloperidone), chlorpromazine, Symbyax (olanzapine/fluoxetine)]; **OR**
C. Irritability associated with autism [Risperdal (risperidone), Abilify (aripiprazole) – not Abilify Mycite formulation, Opipza (aripiprazole) oral film]; **OR**
D. Severe behavioral problems including explosive hyperexcitability which cannot be accounted for by immediate provocation (chlorpromazine, haloperidol);

AND

VII. One of the following:
A. Individual has utilized non-drug treatment measures, such as psychosocial intervention/care, in the previous 12 months with the most recent psychosocial treatment event occurring withing the last 90 days (provide date of most recent behavioral health visit); **OR**
B. Individual has had an acute inpatient visit for a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder in the previous 12 months; **OR**
C. Individual has had at least 2 visits in outpatient, intensive outpatient, or partial hospitalization setting for a diagnosis of schizophrenia, bipolar disorder or other psychotic disorder in the previous 12 months;

AND

VIII. Prescriber will monitor at least every 6 months for metabolic side effects (including obtaining blood glucose or Hemoglobin A1C (HbA1c), total cholesterol or LDL-C, reviewing BMI changes);
AND
IX. Prescriber will regularly monitor for neurological side effects [such as, evaluation of movement disorders using tools including Abnormal Involuntary Movement Scale (AIMS) and the Neurological Rating Scale (NRS)];

OR

X. Individual is requesting an antipsychotic agent to treat the following diagnoses:
A. Nausea and vomiting (chlorpromazine, perphenazine, prochlorperazine); **OR**
B. Tourette's Disorder/tic disorder [Orap (pimozide), Abilify (aripiprazole) – not Abilify Mycite formulation, haloperidol, Opipza (aripiprazole) oral film]; **OR**
C. Pre-surgical apprehension (chlorpromazine);

AND

XI. No therapeutic alternative exists or therapeutic alternatives were ineffective.

Continuation of therapy requests for antipsychotic agents in the pediatric population (age 17 and under) may be approved when the following criteria are met:

I. Criteria above were met at initiation of therapy; **AND**
II. There is clinically significant improvement or stabilization in clinical signs and symptoms of disorder; **AND**
III. Individual is currently utilizing or has utilized non-drug treatment measures, such as psychosocial intervention/care, in the previous 12 months; **AND**
IV. Prescriber is monitoring laboratory values (including blood glucose or Hemoglobin A1C (HbA1c), and total cholesterol or LDL-C) for metabolic side effects at least every 6 months; **AND**
V. Prescriber is monitoring body weight and BMI at least quarterly; **AND**
VI. Prescriber is regularly monitoring for neurological side effects.

Key References:

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3. DailyMed. Package inserts. U.S. National Library of Medicine, National Institutes of Health website. http://dailymed.nlm.nih.gov/dailymed/about.cfm. Accessed: January 6, 2025.
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7. McClellan JJ. Practice parameter for the assessment and treatment of children and adolescents with schizophrenia. Journal of the American Academy of Child and Adolescent Psychiatry. 2013-09;52:976-990. Accessed January 6, 2025.
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