Gateway Health It's Wholecare.

Gateway Health Plan
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Antipsychotics

A. Prescriptions That Require Prior Authorization

Prescriptions for Antipsychotics that meet any of the following conditions must be prior authorized:

1. A non-preferred Antipsychotic. See the Preferred Drug List (PDL) for the list of preferred Antipsychotics at: https://papdl.com/preferred-drug-list.

2. An Antipsychotic when prescribed for a child under 18 years of age.

3. An atypical Antipsychotic when there is a record of a recent paid claim for another atypical Antipsychotic (therapeutic duplication).

4. A typical Antipsychotic when there is a record of a recent paid claim for another typical Antipsychotic (therapeutic duplication).

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antipsychotic, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For Invega (paliperidone), **one** of the following:

   a. Has a history of therapeutic failure, contraindication, or intolerance of the preferred Antipsychotics,
   b. Has active liver disease with elevated LFTs or is at risk for active liver disease,
   c. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antipsychotic (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred);

   AND

2. For all other non-preferred Antipsychotics, **one** of the following:

   a. Has a history of therapeutic failure, contraindication, or intolerance (such as, but not limited to, diabetes, obesity, etc.) to the preferred Antipsychotics
   b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antipsychotic (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred);

   AND

3. For an Antipsychotic for a child under the age of 18 years, **all** of the following:

   a. Has severe behavioral problems related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses:

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i. Autism spectrum disorder,
ii. Intellectual disability,
iii. Conduct disorder,
iv. Bipolar disease,
v. Tic disorder, including Tourette's syndrome,
vi. Transient encephalopathy,
vii. Schizophrenia,

b. **One** of the following:

i. If less than 14 years of age, is being prescribed the medication by or in consultation with **one** of the following:

a) Pediatric neurologist,
b) Child and adolescent psychiatrist,
c) Child development pediatrician,

ii. If 14 years of age or older, is being prescribed the medication by or in consultation with **one** of the following:

a) Pediatric neurologist,
b) Child and adolescent psychiatrist,
c) Child development pediatrician,
d) General psychiatrist,

c. Has chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies such as, but not limited to, evidence-based behavioral, cognitive, and family based therapies,

d. Has documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS);

AND

4. For therapeutic duplication, **one** of the following:

a. For an atypical Antipsychotic, is being titrated to or tapered from another atypical Antipsychotic,
b. For a typical Antipsychotic, is being titrated to or tapered from another typical Antipsychotic,
b. Has a medical reason for concomitant use of the requested medications that is supported by peer-reviewed literature or national treatment guidelines;

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

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FOR RENEWALS OF PRIOR AUTHORIZATION FOR PREFERRED and NON-PREFERRED ANTIPSYCHOTICS FOR CHILDREN UNDER 18 YEARS OF AGE: The determination of medical necessity of a request for renewal of a prior authorization for an Antipsychotic for a child under 18 years of age that was previously approved will take into account whether the beneficiary:

1. Has **all** of the following:

    a. Documented improvement in target symptoms,
    b. Documented monitoring of weight or BMI quarterly,
    c. Documented monitoring of blood pressure, fasting glucose, fasting lipid panel, and EPS using AIMS after the first 3 months of therapy and then annually,
    d. Documented plan for taper/discontinuation of the Antipsychotic or rationale for continued use.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Except as noted below, prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antipsychotic. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Approvals of requests for prior authorization of prescriptions for an Antipsychotic for a child under 18 years of age will be approved as follows:

1. Up to 3 months for an initial request.
2. Up to 12 months for a renewal of a previously approved request.

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ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Phone of office contact:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Dosage form (tablet, solution, etc.):	Strength:	
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Diagnosis code (*required*):	

REQUEST for a NON-PREFERRED drug	
Has the beneficiary taken the requested non-preferred antipsychotic in the past 90 days?	☐Yes – *Submit documentation.* ☐No
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred medications in this class? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐Yes – *Submit documentation of therapeutic failure.* ☐No
REQUEST for a beneficiary LESS THAN 18 YEARS of age	
Is this request for a dose increase of a previously approved medication?	☐Yes – *Submit recent chart documentation supporting the increased dose.* ☐No
Is the requested agent prescribed by or in consultation with one of the following physician specialists? ☐child development pediatrician ☐general psychiatrist (only if beneficiary is ≥ 14 years of age) ☐child & adolescent psychiatrist ☐pediatric neurologist	☐Yes ☐No *Submit documentation of consultation, if applicable.*
Does the beneficiary have severe behavioral problems related to a psychotic or neuro-developmental disorder (e.g., autism spectrum disorder, bipolar disease, conduct disorder, intellectual disability, schizophrenia, tic disorder [including Tourette's syndrome], transient encephalopathy)?	☐Yes ☐No *Submit medical record documentation.*
Has the beneficiary tried non-drug therapies (e.g., evidence-based behavioral, cognitive, and family-based therapies)?	☐Yes ☐No *Submit documentation of therapies tried.*

Did the beneficiary have the following baseline and/or follow-up monitoring? *Check all that apply and submit documentation for each item.*

- ☐BMI (or weight/height)
- ☐blood pressure
- ☐fasting glucose level
- ☐fasting lipid panel
- ☐presence of extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)

PLEASE FAX COMPLETED FORM TO GATEWAY – PHARMACY DIVISION

Prescriber Signature:	Date: