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PARP Approved: 6/2018

Gateway Health
Prior Authorization Criteria

Antipsychotics for children younger than 18 years of age

All requests for Antipsychotics for children younger than 18 years of age require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Antipsychotics for Children Younger than 18 Years of Age Prior Authorization Criteria:

- Coverage may be provided when there is documented evidence of severe behavioral problems related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses:
    - Autism Spectrum Disorder
    - Intellectual disability
    - Conduct Disorder
    - Bipolar Disorder
    - Tic Disorder, including Tourette's Syndrome
    - Transient encephalopathy
    - Schizophrenia
- Medication is prescribed by, or in consultation with, an appropriate specialist including:
    - Pediatric Neurologist
    - Child and Adolescent Psychiatrist
    - Child Development Pediatrician
    - Adult Psychiatrist when the member is at least 14 years of age
    - Adult Psychiatrist prescribing in conjunction with one of the specialists above for members younger than 14 years of age
- Chart documented evidence is provided of a comprehensive evaluation by the prescriber or in conjunction with a specialist listed above, including documentation that non-pharmacologic therapies such as, but not limited to, evidence based behavioral, cognitive and family based therapies have been tried
- The member has documentation of all of the following measurements within the past year:
    - Weight or body mass index (BMI)
    - Blood pressure
    - Fasting glucose
    - Extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS)
    - Fasting lipid panel
- If the request is for a new start, the following additional criteria must be met:
    - For a non-formulary oral atypical antipsychotic, the member has tried and failed two formulary oral atypical antipsychotics
    - For Latuda, the member has tried and failed one generic formulary oral atypical antipsychotic

    - For clozapine, the member has tried and failed at least two other oral antipsychotics
    - For an injectable, there is evidence tolerability has been established with an oral antipsychotic prior to initiation of an injectable antipsychotic **AND** there is evidence describing compliance concerns with daily oral dosage forms of antipsychotics
- **Initial Duration of Approval:** 3 months
- **Reauthorization criteria**
    - Documentation of all of the following:
        - Improvement in target symptoms
        - Has a documented plan for taper/discontinuation of the antipsychotic or rationale for continued use
        - Chart information supporting monitoring of the following:
            - Weight or BMI
            - Blood pressure
            - Glucose
            - Lipids
            - EPS using AIMS
- **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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.