Highmark Wholecare
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 in the point-of-sale online claims adjudication system (therapeutic duplication).
4. A typical Antipsychotic when there is a record of a recent paid claim for another typical Antipsychotic in the point-of-sale online claims adjudication system (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 a non-preferred Antipsychotic, **both** of the following:
    a. **One** of the following:
        i. **All** of the following:
            a) Has a history of therapeutic failure of or a contraindication or an intolerance (such as, but not limited to, diabetes, obesity, etc.) to the preferred Antipsychotics approved or medically accepted for the beneficiary's diagnosis or indication,
            b) Is prescribed the requested Antipsychotic for the treatment of a diagnosis that is consistent with the U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
            c) Is prescribed a dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
        ii. 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)
    b. For Opipza (aripiprazole) film, has a contraindication or an intolerance to aripiprazole ODT that would not be expected to occur with Opipza (aripiprazole) film;

AND

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

   a. Is age-appropriate according to U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

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

      i. Autism spectrum disorder,
      ii. Intellectual disability,
      iii. Conduct disorder,
      iv. Bipolar disorder,
      v. Mood disorders with psychotic features,
      vi. Tic disorder, including Tourette's syndrome,
      vii. Transient encephalopathy,
      viii. Schizophrenia and schizophrenia-related disorders,

   c. **One** of the following:

      i. If under 14 years of age, is prescribed the drug 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 prescribed the drug by or in consultation with **one** of the following:

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

   d. Has chart documented evidence of a comprehensive evaluation,

   e. Has a documented plan of care that includes non-pharmacologic therapies (e.g., evidence-based behavioral, cognitive, and family based therapies) when indicated according to national treatment guidelines,

   f. For an Antipsychotic with risk of metabolic changes, has documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose or hemoglobin A1c, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS);

AND

3. 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,
c. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical 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.

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. For an Antipsychotic with risk of metabolic changes, **both** of the following:

      i. Documented monitoring of weight or BMI quarterly
      ii. Documented monitoring of blood pressure, fasting glucose or hemoglobin A1c, fasting lipid panel, and EPS using AIMS after the first three months of therapy and then annually,

   c. Documented plan for taper/discontinuation of the Antipsychotic or rationale for continued use;

   AND

2. For a non-preferred Antipsychotic with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug

   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

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

1. Initial requests for prior authorization of an Antipsychotic for a child under 18 years of age will be approved for up to three months.
2. Renewals of requests for prior authorization of an Antipsychotic for a child under 18 years of age will be approved for up to 12 months.

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ANTIPSYCHOTICS PRIOR AUTHORIZATION FORM *(effective 1/5/2026)*

☐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:		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*):	
Is the beneficiary currently being treated with the requested medication?	☐Yes – date of last dose: _____ *Submit documentation.* ☐No		

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a NON-PREFERRED Antipsychotic:

☐The beneficiary tried and failed or has a contraindication or an intolerance (such as diabetes, obesity, etc.) to the preferred Antipsychotics (*Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐If the request is for **Opipza (aripiprazole) film,** the beneficiary has a contraindication or intolerance to aripiprazole ODT that would not be expected to occur with Opipza film

2. For an Antipsychotic for a child UNDER THE AGE OF 18 YEARS:

☐Is prescribed the Antipsychotic by or in consultation with one of the following specialists:

- ☐a child development pediatrician
- ☐a general psychiatrist (only if beneficiary is ≥14 years of age)
- ☐a child & adolescent psychiatrist
- ☐a pediatric neurologist

☐Has severe symptoms related to psychotic or neurodevelopmental disorders such as seen in the following diagnoses:

- ☐autism spectrum disorder
- ☐mood disorders with psychotic features
- ☐bipolar disorder
- ☐schizophrenia & schizophrenia-related disorders
- ☐conduct disorder
- ☐tic disorder (including Tourette's syndrome)
- ☐intellectual disability
- ☐transient encephalopathy

☐Has chart documented evidence of a comprehensive evaluation

☐Has a documented plan of care that includes non-pharmacologic therapies (eg, evidence-based behavioral, cognitive, and family-based therapies) when indicated according to national treatment guidelines

☐**For an Antipsychotic with risk of metabolic changes:** Has documented baseline monitoring of the following:

- ☐blood pressure
- ☐extrapyramidal symptoms using Abnormal Involuntary Movement Scale (AIMS)
- ☐fasting lipid panel
- ☐weight or BMI
- ☐fasting glucose or HbA1c

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RENEWAL requests for a child UNDER THE AGE OF 18 YEARS

1. For an Antipsychotic for a child UNDER THE AGE OF 18 YEARS:

- ☐ Has documented improvement in target symptoms
- ☐ **For an Antipsychotic with risk of metabolic changes:** Has documented quarterly monitoring of weight or BMI
- ☐ **For an Antipsychotic with risk of metabolic changes:** Has documented monitoring of the following after the first 3 months of therapy and annually thereafter:
  - ☐ blood pressure
  - ☐ fasting glucose or HbA1c
  - ☐ fasting lipid panel
  - ☐ extrapyramidal symptoms using Abnormal Involuntary Movement Scale (AIMS)
- ☐ Has a documented plan for taper/discontinuation of the Antipsychotic drug
- ☐ Has a documented rationale for continued use of the Antipsychotic drug

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**:

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