NYRx Drug Class Coverage Overview: Antipsychotics – Second Generation

NYRx Preferred Drug List

Drugs in the Antipsychotics – Second Generation drug class are included on the NYRx Preferred Drug List (PDL) and are subject to prior authorization (PA) requirements:

<table>
<tr><th>Preferred Drugs</th><th>Non-Preferred Drugs</th><th>Coverage Parameters</th></tr>
<tr><td colspan="3">IV. Central Nervous System</td></tr>
<tr><td colspan="3">Antipsychotics – Second Generation CC, ST</td></tr>
<tr>
<td>aripiprazole tablet DO
asenapine (gen Saphris®)
clozapine
lurasidone (gen Latuda®)
olanzapine tablet DO
paliperidone ER DO
quetiapine F/Q/D
quetiapine ER F/Q/D, DO
risperidone
ziprasidone capsule</td>
<td>Abilify® tablet DO
Abilify MyCite®
aripiprazole solution
aripiprazole ODT
Caplyta™
clozapine ODT
Clozaril®
Cobenfy™ capsules, starter pack
Fanapt®
Geodon®
Invega® DO
Latuda® DO
Lybalvi®
Nuplazid®
olanzapine ODT DO
olanzapine / fluoxetine
Opipza™
Rexulti® DO
Risperdal®
Saphris®
Secuado®
Seroquel® F/Q/D
Seroquel XR® DO, F/Q/D
Versacloz®
Vraylar® DO
Zyprexa® DO
Zyprexa® Zydis</td>
<td>DOSE OPTIMIZATION (DO)
• See Dose Optimization Chart for affected drugs and strengths
CLINICAL CRITERIA (CC)
• Confirm diagnosis of FDA-approved or compendia-supported indication
• Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA
• PA is required when an oral SGA is utilized above the highest MDD according to FDA labeling.
• PA is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days.
• PA is required for patients 21 years of age or older when 3 or more different oral second-generation antipsychotics are used for more than 180 days.
• PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:
<table>
<tr><td>aripiprazole (Abilify®, Opipza™)</td><td>6 years</td></tr>
<tr><td>aripiprazole (Abilify MyCite®)</td><td>18 years</td></tr>
<tr><td>asenapine (Saphris®)</td><td>10 years</td></tr>
<tr><td>asenapine (Secuado®)</td><td>18 years</td></tr>
<tr><td>brexpiprazole (Rexulti®)</td><td>13 years</td></tr>
<tr><td>cariprazine (Vraylar®)</td><td>18 years</td></tr>
<tr><td>clozapine (Clozaril®, Versacloz®)</td><td>12 years</td></tr>
<tr><td>iloperidone (Fanapt®)</td><td>18 years</td></tr>
<tr><td>lumateperone (Caplyta™)</td><td>18 years</td></tr>
<tr><td>lurasidone HCl (Latuda®)</td><td>10 years</td></tr>
<tr><td>olanzapine (Zyprexa®)</td><td>10 years</td></tr>
<tr><td>olanzapine / fluoxetine (Symbyax®)</td><td>10 years</td></tr>
<tr><td>olanzapine / samidorphan (Lybalvi®)</td><td>18 years</td></tr>
<tr><td>paliperidone ER (Invega®)</td><td>12 years</td></tr>
</table>
</td>
</tr>
</table>

Preferred Drugs	Non-Preferred Drugs	Coverage Parameters
IV. Central Nervous System		
Antipsychotics – Second Generation CC, ST		
		pimavanserin (Nuplazid®) — 18 years quetiapine fum. (Seroquel®, Seroquel XR®) — 10 years risperidone (Risperdal®) — 5 years xanomeline-trospium (Cobenfy™) — 18 years ziprasidone HCl (Geodon®) — 10 years • Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age **STEP THERAPY (ST)** • For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required • olanzapine / fluoxetine: When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required **FREQUENCY/QUANTITY/DURATION (F/Q/D)** • **quetiapine/quetiapine ER (Seroquel®/Seroquel XR®):** Minimum 50 mg/day • **quetiapine (Seroquel®):** Maximum 3 units per day, 90 units per 30 days • **quetiapine ER (Seroquel XR®):** 50mg, maximum 2 units/day, 60 units/30 days

Prior Authorization Requirements

- Preferred drugs will not require PA if the required coverage parameters are found in the member's Medicaid claim history at the time of pharmacy claim submission and if clinical criteria are met as outlined on the PDL. Patients who are stabilized on a non-preferred drug may continue to receive that drug without PA.
- Clinical Criteria requirements outlined in the PDL are in response to recommendations from the Drug Utilization Review Board (DURB), FDA labeling, and/or clinical practice guidelines and include:
  - Confirm diagnosis of FDA-approved or compendia-supported indication.
  - Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA.
  - PA is required when an oral SGA is utilized above the highest maximum daily dose according to FDA labeling.
  - PA is required for patients less than 21 years of age when there is concurrent use of two or more different oral antipsychotics for greater than 90 days, or for patients 21 years of age or older when 3 or more different oral SGAs are used for more than 180 days.
  - PA is required for the initial prescription for beneficiaries younger than the drug specific minimum age indicated in the above chart.

  - Require confirmation of diagnosis that supports the concurrent use of an SGA and a CNS Stimulant for patients less than 18 years of age.
- Step Therapy (ST) requirements outlined in the PDL:
  - For all SGAs used in the treatment of Major Depressive Disorder (MDD) in the absence of other psychiatric comorbidities, a trial with at least two different antidepressant agents is required.
- Frequency/Quantity/Duration (F/Q/D) requirements outlined in the PDL:
  - quetiapine/quetiapine ER (Seroquel®/ Seroquel XR®): Minimum 50 mg/day
  - quetiapine (Seroquel®): Maximum 3 units per day, 90 units per 30 days
  - Quetiapine ER (Seroquel XR®): Maximum 50 mg, 2 units per day, 60 units per 30 days
- Dose Optimization (DO) requirements outlined in the PDL for the following drugs are:

Brand Name	Dose Optimization Limitations		
CENTRAL NERVOUS SYSTEM			
Antipsychotics – Second Generation			
Abilify® 2 mg	4 daily	Tablet	
Abilify® 5 mg, 10 mg, 15 mg	1 daily	Tablet	In case of dose titration for these medications, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months
aripiprazole 5 mg, 10 mg, 15 mg	1 daily	Tablet	
Invega® 1.5 mg, 3 mg	1 daily	Tablet	
Latuda® 20 mg, 40 mg, 60 mg	1 daily	Tablet	
olanzapine 5 mg, 10 mg	1 daily	Tablet	
olanzapine ODT 5 mg, 10 mg	1 daily	Tablet	
paliperidone er 1.5 mg, 3 mg	1 daily	Tablet	
quetiapine fumarate er 200 mg, 150 mg	1 daily	Tablet	
Rexulti® 0.25 mg, 0.5 mg, 1 mg, 2 mg	1 daily	Tablet	
Seroquel® XR 150 mg, 200 mg	1 daily	Tablet	
Vraylar® 1.5 mg, 3 mg	1 daily	Capsule	
Zyprexa® Zydis 5 mg, 10 mg	1 daily	Tablet	

Note: In case of dose titration for these medications, multiday dosing (up to 2 doses/daily) for titration purposes for three months will be allowed.

Olanzapine/Fluoxetine (Symbyax®)

- When prescribing for the treatment of MDD in the absence of other psychiatric comorbidities, a trial with at least one different antidepressant agent other than fluoxetine is required.
- PA is required for the initial prescription for beneficiaries younger than ten years.

What Providers Need to Know

- Pharmacy providers should become familiar with the Antipsychotics – Second Generation coverage criteria and the PDL and incorporate this information when discussing the need for PA with prescribers.

- State law requires Medicaid to cover an FDA-approved generic product, where an A-rated generic equivalent is available, instead of the brand name drug. Coverage of brand name drugs that are in the Mandatory Generic Drug Program will require a prior authorization. Drugs in the Preferred Drug Program (PDP) or the Brand Less than Generic (BLTG) Program are excluded from this requirement. For more information, see the Overview of the Mandatory Generic Drug Program (MGDP).
- Olanzapine/Fluoxetine (Symbyax®) is part of the MGDP due to the additional criteria required if the brand is requested.

What Prescribers Need to Do

- Prescribers should become familiar with the Antipsychotics – Second Generation coverage criteria and the PDL and incorporate this information when prescribing for Medicaid members.
- Prescribers should ensure that medical records are up to date with appropriate diagnosis for members.
- If a PA is needed, prescribers should utilize the NYRx the Medicaid Pharmacy Program Atypical Antipsychotics (AAP) Prior Authorization Worksheet. This worksheet outlines requirements, including ICD code to confirm diagnoses and other necessary clinical information needed for submission of a PA.

Resources

- NYRx Education & Outreach Website
- NYRx Overview of the Mandatory Generic Drug Program
- NYRx Preferred Drug List
- NYRx Prior Authorization Submission Guide
- NYRx the Medicaid Pharmacy Program Atypical Antipsychotics (AAP) Prior Authorization Worksheet

Contact Information

The NYRx Education & Outreach Call Center is available by phone at 1-833-967-7310 or by email at NYRxEO@primetherapeutics.com from 8:00 AM to 5:00 PM ET, Monday through Friday, excluding holidays.

The NYRx Education & Outreach team hosts virtual office hours every week for stakeholders to ask questions related to NYRx and care coordination. Visit the NYRx Education & Outreach website for more information.