# NYRx Drug Class Coverage Overview: Antipsychotics – Second Generation

## NYRx Preferred Drug List

Drugs in the Antipsychotics – Second Generation (SGA) 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>Prior Authorization/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<br>asenapine (gen Saphris®)<br>clozapine<br>lurasidone (gen Latuda®)<br>olanzapine tablet DO<br>paliperidone ER DO 1<br>quetiapine F/Q/D<br>quetiapine ER F/Q/D, DO<br>risperidone<br>ziprasidone capsule</td><td>Abilify® tablet DO<br>Abilify MyCite®<br>aripiprazole solution<br>aripiprazole ODT<br>Caplyta™<br>clozapine ODT<br>Clozaril®<br>Fanapt®<br>Geodon®<br>Invega® DO<br>Latuda® DO<br>Lybalvi™<br>Nuplazid®<br>olanzapine ODT DO<br>Rexulti® DO<br>Risperdal®<br>Saphris®<br>Secuado®<br>Seroquel® F/Q/D<br>Seroquel XR® DO, F/Q/D<br>Versacloz®<br>Vraylar® DO<br>Zyprexa® DO<br>Zyprexa® Zydis</td><td>DOSE OPTIMIZATION (DO)<br>• See Dose Optimization Chart for affected drugs and strengths<br><br>CLINICAL CRITERIA (CC)<br>• Confirm diagnosis of FDA-approved or compendia-supported indication<br>• Clinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PA<br>• Prior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling.<br>• Prior authorization 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.<br>• Prior authorization 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.<br>• PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:
<table>
<tr><td>aripiprazole (Abilify®)</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>paliperidone ER (Invega®)</td><td>12 years</td></tr>
<tr><td>pimavanserin (Nuplazid®)</td><td>18 years</td></tr>
<tr><td>quetiapine fum. (Seroquel®, Seroquel XR®)</td><td>10 years</td></tr>
<tr><td>risperidone (Risperdal®)</td><td>5 years</td></tr>
<tr><td>ziprasidone HCl (Geodon®)</td><td>10 years</td></tr>
</table>
</td></tr>
</table>

| Preferred Drugs | Non-Preferred Drugs | Prior Authorization/Coverage Parameters |
|---|---|---|
| IV. Central Nervous System | | |
| Antipsychotics – Second Generation CC, ST | | |
| | | • Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age<br>**STEP THERAPY (ST)**<br>• 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<br>**FREQUENCY/QUANTITY/DURATION (F/Q/D)**<br>• **quetiapine/quetiapine ER (Seroquel®/Seroquel XR®):** Minimum 50 mg/day<br>• **quetiapine (Seroquel®):** Maximum 3 units per day, 90 units per 30 days<br>• **quetiapine ER (Seroquel XR®)**: Maximum150 mg, 1 unit/day, 30 units/30 days<br>• **quetiapine ER (Seroquel XR®):** Maximum 50 mg, 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.
  - 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 three or more different oral second-generation antipsychotics are used for more than 180 days.
  - Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients less than 18 years of age.
  - PA is required for the initial prescription for beneficiaries younger than the drug specific minimum age indicated in the above chart.

- Step Therapy (ST) requirements outlined in the PDL:
  - For all Second-Generation Antipsychotics used in the treatment of Major Depressive Disorder 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 150 mg, 1 unit per day, 30 units per 30 days
  - Quetiapine ER (Seroquel XR®): Maximum 50 mg, 2 units per day, 60 units per 30 days
- Dose Optimization 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 | 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 | |
| Symbyax® 3–25 mg, 6–25 mg, 12–25 mg | 1 daily | Capsule | |
| 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, the Department will allow for multiday dosing (up to 2 doses/daily) for titration purposes for three months.

## Olanzapine/Fluoxetine (Symbyax®)

- When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, a trial with at least one different antidepressant agent 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.

## 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.

## Resources

- NYRx Education & Outreach Website
- NYRx Preferred Drug List
- NYRx Prior Authorization Submission Guide
- New York State Department of Health Opioid Management Resources

## 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.