Clinical Policy: Concomitant Antipsychotic Treatment

Reference Number: NV.PMN.10
Effective Date: 8/1/2020
Last Review Date: 10/20/2023
Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Concomitant use of more than one, 2nd generation (atypical) antipsychotic

FDA Approved Indication(s)
Treatment refractory schizophrenia spectrum disorders (schizophrenia, schizoaffective and schizophreniform disorders) or bipolar disorder with psychosis and/or severe symptoms.

Limitation of use:

- Cross tapers will automatically be approved for 60 days. Providers must submit a prior authorization request for continued utilization of concomitant use of any 2 atypical antipsychotics beyond the 60 days allowed for cross tapering. This policy includes oral dosage forms in combination with injectable dosage forms of the same agent. (i.e. Abilify and Abilify Maintena; risperidone and Risperdal Consta).

- Prescribers must be contracted behavioral health medical professionals (BHMP).

Policy/Criteria
Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria.

Provider must provide supporting documentation, that adherence to the treatment regimen has not been a contributing factor to the lack of response in the medication trial.

It is the policy of SilverSummit Healthplan that concomitant use of more than one atypical antipsychotic is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Refractory Schizophrenia Spectrum Disorder (must meet all)**:**

1. Diagnosis of schizophrenia, schizoaffective disorder or schizophreniform disorder
2. Evidence of adequate trials of at least three (3) individual antipsychotics, for 4-6 weeks at maximum tolerated does, failure due to:
    a. Inadequate response to maximum tolerated dose
    b. Adverse reaction(s), or
    c. Break through symptoms
3. Provider must provide supporting documentation, that adherence to the treatment regimen has not been a contributing factor to the lack of response in the medication trials.

Approval duration: 6 months

B. Refractory Bipolar Disorder with Psychosis and/or Severe Symptoms (must meet all)**:**

1. Diagnosis of bipolar disorder
2. Evidence of adequate trials of at least four (4) evidence based treatment options dependent upon the episode type. Trials may include, but are not limited to, combination therapy of antipsychotics and mood stabilizers and/or anticonvulsants.
    a. Trials should be 4-6 weeks of maximum tolerated doses, with failure due to:
    b. Inadequate response to maximum tolerated dose
    c. Adverse reaction(s),
    d. Break through symptoms
3. Provider must provide supporting documentation, that adherence to the treatment regimen has not been a contributing factor to the lack of response in the medication trials.

Approval duration: 6 months

II. Continued Therapy

A. Refractory Schizophrenia Spectrum Disorder and refractory bipolar disorder with psychosis and/or severe symptoms (must meet all)**:**

1. Currently receiving medication via a health plan affiliated with Centene Corporation or member has previously met initial approval criteria;
2. Documentation of positive response to therapy [labs, sign/symptom reduction, etc.];

Approval duration: 12 months

III. Diagnoses/Indications for which coverage is NOT authorized:

1. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off-label use policy – CP.PMN.53 or evidence of coverage documents
2. Prescriptions written by **non**-behavioral health professionals

IV. Appendices/General Information

Appendix A. Abbreviation/Acronym Key
BHMP: Behavioral Health Medical Professional

Appendix B. General Information
N/A

Appendix C: Therapeutic Alternatives
N/A

V. Dosage and Administration*

**Only Preferred or formulary atypical antipsychotics listed.*

Drug Name	Indication	Dosing Regimen	Maximum Dose
Aripiprazole (Abilify, Abilify Maintena, Aristada, Abilify MyCite)	Schizophrenia	Adults:10-30mg PO/day Adolescents: 2-30mg/day	30mg PO/day
		Adults:Maintena:300-400mg IM/ month	400mg IM/month
		Adults: Aristada: 441mg-882mg IM/ 6 weeks 1064mg IM/ 2 months	882mgIM/month Or 1064mg Q2 months
	Bipolar	Adults: 15mg-30mg PO/day Children-Adolescents: 2-30mg PO day	30mg PO/day
		Maintena: 300-400mg IM/month	400mgIM/month
		Abilify MyCite: 5mg-30mg daily	30mg PO/day
Aristada	Schizophrenia	Adults: 441mg-882mg IM/month	441mg, 662mg, 882mg IM/month
		882mg IM every 4-6 weeks	882mg IM/6 weeks
		1064mg IM every 2 months	1064mg IM/2 months
Aristada Initio		675mg IM single dose	675mg IM/month (max 1 dose for initiation of therapy)
Clozapine (Clozaril, Fazaclo)	Schizophrenia, schizoaffective	Adults:12.5mg-450mg/day in divided doses	Adults:900mg PO/day
		Children &	

		Adolescents: 6.25mg – 300mg/day	Children & Adolescents: 300mg PO/day
	Bipolar (off label)	50mg-400mg/day	400mg PO/day
Lurasidone (Latuda)	Schizophrenia	Adults: 20mg-120mg/day Adolescents: 40mg-80mg/day	Adults: 160mg PO/day Adolescents: 80mg PO/day
	Bipolar Depression	Adults: 20mg-120mg/day Children &Adolescents: 20mg-80mg QD	Adults: 120mg PO/day Children &Adolescents: 80mg PO/day
Olanzapine (Zyprexa, Zyprexa Zydis)	Schizophrenia	Adults: 5mg- 10mg QD Children & Adolescents: 2.5mg-10mg QD	Adults: 10mg PO/day Children & Adolescents: 10mg PO/day8
	Bipolar	Adults: 10mg-20mg QD Adolescents: 2.5mg-10mg QD	Adults: 20mg PO/day Adolescents: 10mg PO/day
Paliperidone (Invega Sustenna, Invega Trinza)	Schizophrenia/ Schizoaffective disorder	Adults: Sustenna: 39-234mg IM Q monthly Trinza: 273-819mg IM Q 3 months	Sustenna: 234mg IM every month Trinza: 819mg IM every 3 months
Quetiapine (Seroquel IR)	Schizophrenia	Adults: 25mg-800mg/day Adolescents: 25mg-400mg/day	Adults and Adolescents: 800mg PO/day Children > 10 years: 600mg PO/day
	Bipolar	Adults: 50mg-800mg QD	

		Children & Adolescents: 25mg-600mg/day	
Risperidone (Risperdal, Risperdal Consta, Perseris)	Schizophrenia	Adults: 2mg-16mg PO/day Adolescents: 0.5mg-6mg PO/day Consta: Adults: 25mg-50mg IM every 2 weeks Perseris: Adults: 90mg or 120mg SC once monthly	16mg PO/day Adolescents: 6mg PO/day 50mg IM Q 2 weeks 120mg IM Q 4 weeks
	Bipolar	Adults: 2-6mg/day PO Children & Adolescents: 0.5mg-6mg/day	6mg PO/day
Ziprasidone (Geodon)	Schizophrenia	Adults: 20mg-80mg PO BID	160mg PO/day
	Bipolar	Adults: 20mg-80mg PO BID	160mg PO/day

VI. Product Availability

Drug	Availability
Aripiprazole (Abilify, Abilify Maintena, , Abilify MyCite)	Tablets: 2mg, 5mg, 10mg, 15mg, 20mg, 30mg Orally disintegrating tablet:10mg, 15mg Oral solution: 1mg/ml Powder for suspension for IM injection, syringe and vial: Abilify Maintena: 300 and 400mg Suspension for IM Injection: Aristada 441mg/1.6ml; 662mg/2.4ml; 882mg/3.2ml; 1064mg/3.9ml Tablet with sensor: Abilify MyCite 2mg, 5mg, 10mg, 15mg, 20mg, 30mg
Aripiprazole Lauroxil (Aristada Intio, Aristada)	Suspension for IM Injection, Extended-release: Aristada Initio: 675mg/2.4ml Suspension for IM Injection, Extended-release: Aristada 1064mg/3.9ml; 441mg/1.6ml; 882mg/3.2ml; 662mg/2.4ml
Clozapine (Clozaril, Fazaclo,)	Orally disintegrating tablet: 12.5mg, 25mg, 100mg, 150mg, 200mg Tablets: 12.5mg, 25mg, 50mg, 100mg, 200mg Oral Suspension: Versacloz 50mg/ml
Lurasidone (Latuda)	Tablets: 20mg, 40mg, 60mg, 80mg, 120mg
Olanzapine (Zyprexa, Zyprexa Zydis)	Orally disintegrating tablet: 5mg, 10mg, 15mg, 20mg Tablet: 2.5mg, 5mg, 7.5mg, 10mg, 15mg, 20mg Powder for Soln ing: 10mg Powder for Susp: 210mg, 300mg, 405mg

Paliperidone (Invega Sustenna, Invega Trinza)	Tablets: 1.5mg, 3mg, 6mg, 9mg Suspension for injection: Sustenna: 39mg/0.25ml; 78mg/0.5ml; 117mg/0.75ml; 156mg/1ml; 234mg/1.5ml Trinza: 273mg, 410mg, 546mg, 819mg
Quetiapine (Seroquel IR) Quetiapine (Seroquel XR)	Tablets: 25mg, 50mg, 100mg, 200mg, 300mg, 400mg Tablets: 50mg, 150mg, 200mg, 300mg, 400mg
Risperidone(Risperdal, Risperdal Consta, Perseris)	Orally disintegrating tablets: 0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg Oral solution: 1mg/ml Tablet: 0.25mg, 0.5mg, 1mg, 2mg, 3mg, 4mg Powder for solution for injection (Consta): 12.5mg, 25mg, 37.5mg, 50mg
Ziprasidone (Geodon)	Capsules: 20mg, 40mg, 60mg, 80mg

VII. References

1. Correll CU, Rummel-Kluge C, Corves C, et al. Antipsychotic combinations vs monotherapy in schizophrenia: A meta-analysis of randomized controlled trials. Schizophrenia Bulletin, 2009; **35**: 443- 457.
2. Essock SM, Schooler NR, Stroup TS, et al. Effectiveness of switching from antipsychotic polypharmacy to monotherapy. Am. J. Psychiatry, 2011; **168**:702-708.
3. Tandon R, Belmaker RH, Gattaz WF, et al. World Psychiatric Association Pharmacopsychiatry Section statement on comparative effectiveness of antipsychotics in the treatment of schizophrenia. Schizophrenia Research, 2008; **100**: 20-38.
4. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2019. Available at: Clinical Pharmacology Home (clinicalkey.com).

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	05/20	07/20

2021 Annual Review – minor grammatical and formatting changes corrected	06/21	7/21
2022 Annual Review – Reviewed and approved by SSHP P&T Committee	01/22	01/22
2022 Annual Review – Updated Clinical Pharmacology data base URL Reviewed and approved by SSHP P&T Committee	10/22	10/22
2023 Annual Review- Updated product availability. Reviewed grammar and spelling. Change of policy name from "NV.CP.PMN.10" to "NV.PMN.10". For Refractory Schizophrenia Spectrum Disorder, removed the requirement of antipsychotics tried and failed needing to be from SSHP preferred drug list to comply with Nevada SB167. Annual review and approval by SSHP P&T Advisory Committee.	10/23	10/23

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.