

MEDICAL ASSISTANCE HANDBOOK  
PRIOR AUTHORIZATION OF PHARMACEUTICAL SERVICES

**I. Requirements for Prior Authorization of Atypical Antipsychotics**

A. Prescriptions That Require Prior Authorization

Prescriptions for Atypical Antipsychotics that meet any of the following conditions must be prior authorized:

1. A prescription for a non-preferred Atypical Antipsychotic, regardless of the quantity prescribed. See Preferred Drug List (PDL) for the list of preferred Atypical Antipsychotics at: [http://www.providersynergies.com/services/documents/PAM\\_PDL\\_20101115.pdf](http://www.providersynergies.com/services/documents/PAM_PDL_20101115.pdf)
2. A prescription for a preferred Atypical Antipsychotic with a prescribed quantity that exceeds the quantity limit. See Quantity Limits for the list of drugs with quantity limits at: [http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s\\_002077.pdf](http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/document/s_002077.pdf).
3. A prescription for either a preferred or non-preferred Atypical Antipsychotic regardless of quantity limit when prescribed for a child under 6 years of age.
4. A prescription for an Atypical Antipsychotic when there is a record of a recent paid claim for another drug within the same therapeutic class of drugs in the Department's Point-of-Sale On-Line Claims Adjudication System, (therapeutic duplication)

GRANDFATHER PROVISION – The Department will grandfather prescriptions for non-preferred Atypical Antipsychotics for those recipients age 6 years and older who are currently being prescribed a non-preferred Atypical Antipsychotic. The Department's Point-of-Sale On-Line Claims Adjudication System will verify if the recipient has a record of a prescription for a non-preferred Atypical Antipsychotic within the past 365 days from the date of service of the new claim. If the recipient has a record of a prescription for a non-preferred Atypical Antipsychotic, a prescription or a refill for the same non-preferred Atypical Antipsychotic will be automatically approved.

Grandfathering does not apply to children under 6 year of age when prescribed a preferred Atypical Antipsychotic or to prescriptions for Atypical Antipsychotics that are therapeutic duplications.

B. Clinical Review Guidelines and Review of Documentation for Medical Necessity

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In evaluating a request for prior authorization of a prescription for a non-preferred Atypical Antipsychotic, the determination of whether the requested prescription is medically necessary will take into account the following:

1. For Invega - Whether the recipient has:
  - i. A history of therapeutic failure of at least one (1) other preferred Atypical Antipsychotic; **OR**
  - ii. Active liver disease with elevated LFTs or is at risk for active liver disease
  
2. For all other non-preferred Atypical Antipsychotics - Whether the recipient has:
  - a. A history of therapeutic failure of one (1) preferred Atypical Antipsychotic; **OR**
  - b. A current history (within the past 365 days) of being prescribed the same non-preferred Atypical Antipsychotic
  
3. For a preferred or non-preferred Atypical Antipsychotic for a child under the age of 6 years – Whether the recipient
  - a. Has severe behavioral problems related to psychotic or neuro-developmental disorders such as seen in the following diagnoses::
    - i. Autism, **OR**
    - ii. Mental retardation, **OR**
    - iii. Severe Oppositional Defiant Disorder (ODD) with aggression, **OR**
    - iv. Bipolar disease, **OR**
    - v. Tourette's Syndrome, **OR**
    - vi. Transient encephalopathy

**AND**

- b. Is being prescribed the medication by an appropriate specialist or in consultation with a:
  - i. Pediatric Neurologist, **OR**
  - ii. Child and Adolescent Psychiatrist. **OR**
  - iii. Child Development Pediatrician

**AND**

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- c. Has chart documented evidence of a comprehensive evaluation, including non-pharmacologic therapies such as, but not limited to, evidence based behavioral, cognitive, and family based therapies
4. For therapeutic duplication, whether:
- a. The recipient is being titrated to, or tapered from, a drug in the same class
- OR
- b. Supporting peer reviewed literature or national treatment guidelines corroborate concomitant use of the medications being requested
6. In addition, if a prescription for either a preferred or non-preferred Atypical Antipsychotic is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter
- OR
7. Does not meet the clinical review guidelines listed above, but, in the professional judgment of the physician reviewer (a psychiatrist), the services are medically necessary to meet the medical needs of the recipient.

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 the request for a prescription for an Atypical 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 (a psychiatrist) for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer (a psychiatrist), the services are medically necessary to meet the medical needs of the recipient.

NOTE: Approved requests for prior authorization of prescriptions for Symbyax will require the use of two (2) separate prescriptions for Fluoxetine and Zyprexa.

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All requests for prior authorization of an atypical antipsychotic medication for a child under 6 year of age will be automatically forwarded to a physician reviewer (a psychiatrist) for a medical necessity determination. The physician reviewer (a psychiatrist) will prior authorize the prescription when:

1. The guidelines in Section B. 4. are met, **OR**
2. In the professional judgment of the physician reviewer (a psychiatrist), the services are medically necessary to meet the medical needs of the recipient,

References:

1. Kowatch RA, Fristad M, Birmaher B, et al. Treatment guidelines for children and adolescents with bipolar disorder. *J Am Acad Child Adolesc Psychiatry.* 2005; 44(3): 213-235
2. Schur SB, Sikich L, Findling RL, et al. Treatment recommendations for the use of antipsychotics for aggressive youth (TRAAY). Part I: a review. *J Am Child Adolesc Psychiatry.* 2003; 42(2): 132-144
3. Miller AL, Hall CS, Buchanan RW, Buckley PF. The Texas Medication Algorithm Project antipsychotic algorithm for schizophrenia: 2003 update. *J Clin Psychiatry.* 2004; 65: 500-508
4. Patel NC, Crismon ML, Hoagwood K, et al. Trends in the use of typical and atypical antipsychotics in children and adolescents. *J Am Acad Child Adolesc Psychiatry.* 2005; 44(6): 548-556
5. Centorrino F, et al. Multiple vs single antipsychotic agents for hospitalized psychiatric patients: case-control study of risk vs benefits. *Am J Psychiatry.* 2004; 161: 700-706
6. Greenhill LL. The use of Psychotropic Medication in Preschoolers: Indications, Safety and Efficacy. *Can J Psychiatry* 1998; 43:576-581