BEHAVIORAL HEALTH & RECOVERY SERVICES

SAN MATEO COUNTY

PRIOR AUTHORIZATION PROCEDURES

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Prior Authorization Procedures

Drug products, which are listed as **Prior Authorization (PA) required**, require approval when the member presents a prescription to a network pharmacy. To obtain coverage a pharmacist or physician may:

Fax a completed **Prior Authorization Request** to Health Plan of San Mateo (HPSM) Fax: 650-829-2045.

The request will be reviewed by BHRS staff according to Prior Authorization criteria approved by the BHRS P & T Committee.

If the request meets established criteria, the request will be approved and an authorization given.

If the request does not meet the criteria established by the P & T Committee, the request will be denied.

Failure to submit a Prior Authorization for a listed drug will result in a denial of coverage for the health plan member.

LEGEND	
TYPE	DESCRIPTION
PA	Prior Authorization
QL	Quantity Limit
DS	Day Supply
IR	Immediate Release
ER/XR	Extended Release
ODT	Oral Dissolving Tablet
CR	Controlled Release

Table of Contents

ADHD MEDICATIONS

Drug Name Brand Generic	 Adderall **Amphetamine-Dextroamphetamine IR**
Covered Uses	FDA approved indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 3. Urine Tox screen (see Criteria below)
Age Restriction	Restricted to ADD/ADHD between ages 4-21 PA required for age >21
Prescriber Restriction	None
Other Restriction	QL = #90/30DS *(5mg,7.5mg,10mg,12.5mg,15mg,20mg)* QL = #60/30DS *(30mg)* Approved up to FDA Max dose
Coverage Duration	Variable depending on criteria below
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6 months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2 above

Drug Name Brand Generic	Focalin IR, XR **Dexmethylphenidate IR, XR**
Covered Uses	FDA approved indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 3. Urine Tox screen (see Criteria below) 4. Patient has tried and failed two formulary stimulants, or has had a positive response to this drug in the past
Age Restriction	6 years and older
Prescriber Restriction	None
Other Restriction	QL = #90/30DS for IR *(2.5mg,5mg,10mg)* QL = #30/30DS for XR *(5mg,10mg,15mg,20mg,25mg,30mg,35mg,40mg)* Approved up to FDA Max dose
Coverage Duration	For IR, see other Criteria below Approved XR for 12 months
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines. 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6 months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2 above

Drug Name Brand Generic	 Dexedrine **Dextroamphetamine**
Covered Uses	FDA approved indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 3. Urine Tox screen (see Criteria below)
Age Restriction	Restricted to ADD/ADHD between ages 4-21 PA required for age >21
Prescriber Restriction	None
Other Restriction	QL = #120/30DS *(5mg,10mg)* Approved up to FDA Max dose
Coverage Duration	Variable depending on criteria below
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines. 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6 months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2above

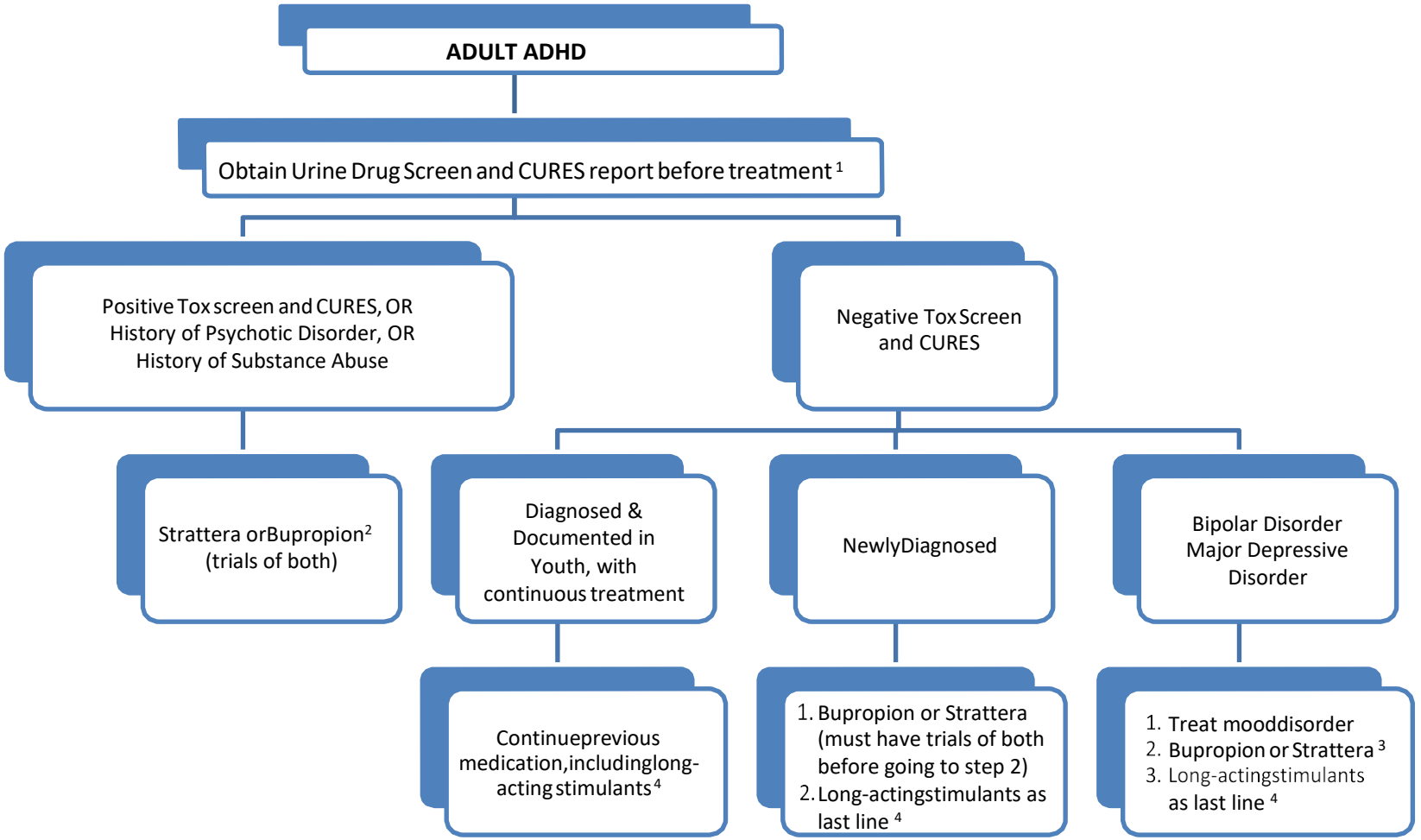
Drug Name Brand Generic	 Xelstrym **Dextroamphetamine transdermal system**
Covered Uses	FDA approved indications Attention deficit hyperactivity disorder
Required Medical Information	
Age Restriction	6 years old and older
Prescriber Restriction	
Other Restriction	#30/30DS (6 to 17 years) Initial, apply one 4.5 mg/9 hour transdermal system topically 2 hours before an effect is needed and remove within 9 hours after application; may titrate in weekly increments of 4.5 mg to MAX 18 mg/9 hours based on individual response and tolerability; use only 1 patch/24 hours; use may be needed for an extended period. Initial, apply one 9 mg/9 hour transdermal system topically 2 hours before an effect is needed and remove within 9 hours after application; may titrate up to MAX 18 mg/9 hours based on individual response and tolerability; use only 1 patch/24 hours; use may be needed for an extended period.
Coverage Duration	Approved all strengths up to 12 months
Other Criteria	Switching amphetamine products: If switching from another medication or any other amphetamine product, discontinue that treatment, and initiate dextroamphetamine transdermal patch using titration schedule; do not substitute for other amphetamine products on a mg-per-mg basis because of different amphetamine base compositions and differing pharmacokinetic profiles

Name Brand Generic	 Desoxyn **Methamphetamine**
Covered Uses	All medically accepted indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Tried and failed two formulary stimulants 3. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 4. Urine Tox screen (see Criteria below)
Age Restriction	Restricted to ADD/ADHD between ages 4-21 PA required for age >21
Prescriber Restriction	None
Other Restriction	QL = #90/30DS Approved up to FDA Max dose
Coverage Duration	Variable depending on criteria below
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines. 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6 months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2above

Drug Name Brand Generic	 Ritalin **Methylphenidate IR**
Covered Uses	FDA approved indications
Required Medical Information	1. If age >21, criteria must be met to start stimulant therapy per BHRS Adult ADHD Guidelines 2. Updated CURES report that does not indicate diversion or misuse (obtained by reviewing pharmacist) 3. Urine Tox screen (see Criteria below)
Age Restriction	Restricted to ADD/ADHD between ages 4-21 PA required for age >21
Prescriber Restriction	None
Other Restriction	QL = #90/30DS for IR *(5mg,10mg,20mg)* Approved up to FDA Max dose
Coverage Duration	Variable depending on criteria below
Other Criteria	1. Treatment initiation phase: approve 90 days to titrate to stable dose, recommend switch over to long-acting formulation and consolidation to one class of stimulant medication 2. Continuation past 90 days: allow only if member a. cannot tolerate side effects of long-acting stimulant, or b. has long-acting formulation for morning, but need short-acting formulation once either in the morning or afternoon c. with sound justification for combination of different classes of stimulants (eg. amphetamine and methylphenidate class) 3. If dosing beyond FDA max or more frequent than 3 times/day (>#90/30DS), approve 30 days up to FDA max and require Urine Tox screen to be submitted for continuation. Approve up to 6 months and only up to FDA max dose if a. Urine Tox screen is positive for requested medication and negative for other amphetamines. 4. If requesting more than one stimulant, approve 30 days for both and request MD to consolidate to one stimulant and submit Urine Tox screen for continuation. Approve up to FDA max dose for 6months if both are provided: a. clear justification for use of two different stimulant class medications b. urine tox screen is positive for requested medications and negative for other amphetamines 5. Approve 12 month ONLY if dosing and frequency within FDA range, and meet Criteria #2above

Drug Name Brand Generic	 Qelbree **Viloxazine**
Covered Uses	ALL medically accepted indications
Required Medical Information	Previous trial of generic atomoxetine OR Client is unable to swallow atomoxetine capsules
Age Restriction	6 yrs of age and older
Prescriber Restriction	None
Other Restriction	QL = #30/30 100mg QL = #60/30 150mg, 200mg
Coverage Duration	Approved all strengths up to 12 months
Other Criteria	

Adult ADHD Treatment Guidelines



1 Obtain random Urine Drug Screen and regular CURES reports during treatment
2 Trials of both Strattera and Bupropion are recommended, consider using Clonidine or Guanfacine as alternatives
3 For other treatment options, please refer to Bond et al. (2012) article: http://www.aacp.com/pdf%2F0212%2F0212ACP_Bond.pdf
4 Use long-acting stimulants to minimize diversion

Rev. 01.2016

Stimulant medication maximum dose for adults					
Drug	**Range**	**FDA max**	**SF county**	**SC county**	**BHRS**
Amphetamines					
Evekio (IR)	5-60mg/day for obesity every 4-6 hrs		40mg		40mg*
	Only in rare cases will it be necessary to exceed 40 mg daily in ADHD				
Adzensys XR or Dyanavel XR	12.5-20mg/day in ADHD, 10-60mg/day in Narcolepsy	20mg	20mg		20mg
Amphetamine salts					
Adderall IR	5-40mg/day for ADHD; 5-60mg/day for narcolepsy Q4-6hrs	rarely necessary to exceed 40mg/	40mg	40mg	40mg
Adderall XR	start with 20mg/day, up to 60mg/day evaluated with? benefit	30mg in peds	30mg	60mg	60mg*
Mydayis (ER lasting 16 hrs)	12.5-50mg/day	50mg			
Dexmethylphenidate					
Focalin IR	5-20mg/day	20mg	20mg	20mg	20mg
Focalin ER	10-40mg/day	40mg	40mg	40mg	40mg
Dextroamphetamine					
Zenzedi or Dexedrine IR	5-60mg/day in 2-3 divided doses for narcolepsy	40mg in peds	40mg	60mg	60mg*
Dexedrine SR	5-60mg QD for narcolepsy	40mg in peds	40mg	60mg	60mg*
	Dosages up to 0.9 mg/kg daily but rarely exceeding 40 mg daily.				
Lisdexamfetamine					
Vyvanse	30-70mg/day	70mg		70mg	70mg
Methamphetamine					
Desoxyn	*Methamphetamine has a high potential for abuse.	* 25mg in peds		25mg	25mg*
The drug should be prescribed or dispensed sparingly and attention should be paid to the possibility of subjects obtaining methamphetamine for non-therapeutic use or distribution to others					
Methylphenidate					
IR	10-60mg/day in 2-3 divided doses	60mg	60mg	60mg	60mg
Aptensio XR	10-60mg/day	60mg	60mg	60mg	60mg
Concerta	18-72mg/day	72mg	72mg		72mg
Metadate CD	20-60mg/day	60mg	60mg	60mg	60mg
Quillichew ER	20-60mg/day	60mg	60mg	60mg	60mg
Ritalin LA	10-60mg/day	60mg	60mg	60mg	60mg
Ritalin SR	20-60mg/day divided every 8 hours	60mg	60mg	60mg	60mg
Daytrana patch	10-30mg/day	30mg	30mg	30mg	30mg
Ref: AHFS DI, Micromedex, Facts&Comparisons, Lexi-Drugs, accessed 10/4/2017					
* Max dose determined by P&T committee after reviewing FDA dosing range and SF/SC county guidelines					
P&T 10/11/2017					

ANTIDEPRESSANT

Drug Name Brand Generic	**Non-Formulary** Zulresso **Brexanolone**
Covered Uses	All FDA-approved indication
Exclusion Criteria	History of aneurysmal vascular disease or arteriovenous malformation, history of intracerebral hemorrhage, hypersensitivity to esketamine/ketamine/excipients.
Required Medical Information	ALL of the following must be met: • Patient has been diagnosed with severe postpartum depression confirmed by a rating scale such as Montgomery- Åsberg depression rating scale (MADRS) with a score of >34 or the Hamilton Rating Scale for Depression (HAM-D) with a score of >25 or PHQ-9 with a score of >20, performed by a psychiatrist; AND • Patient has failed antidepressant medication trials; AND • Patient has failed ECT or is not a candidate for ECT; AND • Patient meets DSM-V diagnosis of PPD: ≤ 6 months postpartum at screening with a major depressive episode with onset no earlier than the third trimester and no later than 4 weeks after delivery; AND • Patient is not currently pregnant; AND • Patient does not have active psychosis, history of schizophrenia, bipolar disorder, or schizoaffective disorder; AND Zulresso is being prescribed by, or in consultation with, a psychiatrist or an obstetrician-gynecologist; AND Zulresso will be administered in a facility that is enrolled in the Zulresso REMS program.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Psychiatrist or obstetrician-gynecologist
Other Restriction	
Coverage Duration	Approved one-time, up to 90mcg/kg/hour x 60-hour infusion, once per postpartum period
Other Criteria	

Drug Name Brand Generic	 Auvelity **Bupropion/Dextromethorphan**
Covered Uses	FDA approved indication of Major Depressive Disorder
Exclusion Criteria	
Required Medical Information	ALL of the following must be met: • Previous adequate trials (at maximum dose for at least 4-6 weeks) of at least two antidepressants from different classes of antidepressants (eg. one from SSRI and one from SNRI) • No contraindication to bupropion such as seizure disorder or conditions that increase risk of seizures • Not pregnant, breastfeeding, or planning pregnancy • Not taking/stopped MAOIs in last 14 days • No abrupt discontinuation of alcohol, benzodiazepines, barbiturates, or antiepileptic drugs • Prescriber attestation of screening for personal/family history of bipolar disorder, mania/hypomania, other meds containing bupropion/dextromethorphan • No history of dextromethorphan abuse
Age Restrictions	18 years of age or older
Prescriber Restrictions	
Other Restriction	QL = 2 tabs per day
Coverage Duration	
Other Criteria	

Drug Name Brand Generic	**Non-Formulary** Spravato **Esketamine Nasal Spray**
Covered Uses	All FDA-approved indication not excluded from Medi-Cal.
Exclusion Criteria	History of aneurysmal vascular disease or arteriovenous malformation, history of intracerebral hemorrhage, hypersensitivity to esketamine/ketamine/excipients.
Required Medical Information	ALL of the following must be met: • Documentation of prescriber's assessment of baseline symptoms severity • Documentation that the patient has tried and failed on 4 antidepressant trials with adequate dose and duration, must include one augmentation trial with lithium or atypical antipsychotic • Documentation of that the patient has tried and failed ECT or has contraindications to ECT • Documentation of use in combination with an antidepressant • Documentation of negative urine tox screen • Documentation of no current or recent substance abuse (within prior 12 months) • Documentation of negative pregnancy test for females of childbearing age • Documentation that the administration site is REMS certified health care facility and that the pharmacy dispensing the drug is REMS certified.
Age Restrictions	18 years of age or older
Prescriber Restrictions	Psychiatrist
Other Restriction	QL = #8/28DS for 56mg kit QL = #7/28DS for 85mg kit
Coverage Duration	3 Months for initial, 6 months upon renewal
Other Criteria	For renewal, documentation of negative urine tox screen and assessment of symptom improvement post treatment.

Drug Name Brand Generic	 Fetzima **Levomilnacipran**
Covered Uses	All FDA approved indications
Required Medical Information	
Age Restriction	18 years of age or older
Prescriber Restriction	
Other Restriction	Up to FDA max of 120 mg once daily
Coverage Duration	All strengths up to 12 months
Other Criteria	

Drug Name Brand Generic	 Paxil CR **Paroxetine Controlled Release**
Covered Uses	All medically accepted indications
Required Medical Information	Patient has tried and failed regular Paroxetine or has had a positive response to this drug in the past.
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	

Drug Name Brand Generic	 Emsam Patch **Selegiline Transdermal**
Covered Uses	All medically accepted indications
Required Medical Information	Patient has tried and failed two formulary antidepressants or Patient cannot tolerate or is noncompliant with oral medications
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	

Drug Name Brand Generic	 Viibryd **Vilazodone**
Covered Uses	All medically accepted indications
Required Medical Information	Documentation required to indicate that patient has tried and failed at least two trials of
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Trintellix **Vortioxetine**
Covered Uses	All medically accepted indications
Required Medical Information	Documentation required to indicate that patient has tried and failed at least two trials formulary antidepressants
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	**Non-Formulary** Zurzuvae **Zuranolone**
Covered Uses	FDA approved indication of Postpartum Depression
Required Medical Information	Documentation of ALL the following: 1. Diagnosis of severe postpartum depression confirmed by a rating scale such as Montgomery-Asberg depression rating scale (MADRS) with a score of greater than 34 or the Hamilton Rating Scale for Depression (HAM-D) with a score of greater than 25 or PHQ-9 with a score of greater than 20, or Edinburg Postnatal Depression Scale (EPDS) of 19 or greater 2. Trial and failure (i.e., inadequate response) of or intolerance to antidepressant therapies 3. Patient meets DSM-V diagnosis of PPD within 6 months postpartum at screening with a major depressive episode with onset no earlier than the third trimester and no later than 4 weeks after delivery.
Age Restriction	18 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with, a psychiatrist, obstetrician, or gynecologist
Other Restriction	Exclusion Criteria: Use in patients who are pregnant or have active psychosis, history of schizophrenia, bipolar disorder, or schizoaffective disorder
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	QL = 28 capsules of 20 mg per 365 days 28 capsules of 25 mg per 365 days 14 capsules of 30 mg per 365 days

ANTIPARKINSON AGENTS

Drug Name Brand Generic	 Cogentin Injectable **Benztropine Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	Patient unable to take oral form of this medication
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 3 months
Other Criteria	

Drug Name Brand Generic	 Parlodel **Bromocriptine**
Covered Uses	All medically accepted indications
Required Medical Information	Patient has tried and failed a formulary antiparkinson agent, or has contraindication to formulary antiparkinson agent, or has had a positive response to this drug in the past or is being treated for drug-induced sexual side effects.
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Benadryl Injectable **Diphenhydramine Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	Patient is unable to take oral form of this medication
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 3 months
Other Criteria	

ANTIPSYCHOTICS

Drug Name Brand Generic	 Abilify Discmelt, Injectable, Oral solution **Aripiprazole ODT, Injectable, Oral solution**
Covered Uses	All medically accepted indications
Required Medical Information	Discmelt or oral solution: unable to tolerate or noncompliant with oral tablet, approve up to 12 months Injectable: unable to tolerate or noncompliant with oral formulations, approve up to 3 months BRAND: tried and failed generic, approve up to 12months
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #30/30DS for oral tabs and discmelt; may override QL during titration up to 3 months
Coverage Duration	Approved for ODT, BRAND, oral solution, all strengths up to 12 months Approved for Injectable or QL up to 3 months
Other Criteria	

Drug Name Brand Generic	 Abilify Asimtufii **Aripiprazole Monohydrate**
Covered Uses	All FDA approved indications
Required Medical Information	Patient has tried and failed oral antipsychotic Or Transferred from hospital/facility/another provider stabilized on this medication
Age Restriction	Adults Only
Prescriber Restriction	
Other Restriction	QL = #1/60DS for 760mg and 960mg
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Aristada Initio **Aripiprazole Lauroxil NanoCrystal Dispersion Technology**
Covered Uses	All medical accepted indications
Required Medical Information	Patient has history of noncompliance with oral antipsychotics or difficulty in swallowing oral medications
Age Restriction	
Prescriber Restriction	
Other Restriction	Approve one dose of Aristada Initio with oral Aripiprazole
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Saphris **Asenapine, sublingual, transdermal**
Covered Uses	All medical accepted indications
Required Medical Information	Documentation required to indicate that patient has tried and failed two trials of formulary antipsychotics
Age Restriction	
Prescriber Restriction	
Other Restriction	Sublingual QL = #60/30DS Transdermal QL = #30/30DS
Coverage Duration	Approved all strengths up to 12 months
Other Criteria	

Drug Name Brand Generic	 Secuado **Asenapine transdermal**
Covered Uses	All medical accepted indications
Required Medical Information	Tried and failed two generic atypical antipsychotics and inability to tolerate or nonadherence to oral or sublingual formulation
Age Restriction	10 years or older
Prescriber Restriction	
Other Restriction	Schizophrenia: 1 patch/24 hours
Coverage Duration	Approved all strengths up to 12 months
Other Criteria	

Drug Name Brand Generic	 Rexulti **Brexpiprazole**
Covered Uses	All medically accepted indications
Required Medical Information	For the treatment of agitation associated with dementia due to Alzheimer's disease: Documentation of diagnosis For ALL other indications: Trial and failure (i.e., inadequate response) of or intolerance to TWO formulary antipsychotics or one generic atypical antipsychotic and one generic antidepressant.
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Vraylar **Cariprazine**
Covered Uses	All medically accepted indications
Required Medical Information	Trial and failure (i.e., inadequate response) of or intolerance to TWO formulary generic atypical antipsychotics
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Fazaclo or Versacloz **Clozapine ODT or Oral solution**
Covered Uses	All medically accepted indications
Required Medical Information	Fazaclo or Versacloz: unable to tolerate or noncompliant with oral tablet BRAND Clozapine: tried and failed generic
Age Restriction	
Prescriber Restrictio006E	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Igalmi **Dexmedatomidine**
Covered Uses	FDA approved indications
Required Medical Information	Adults with acute agitation associated with schizophrenia or bipolar I or II Tried and failed IM Olanzapine or have intolerance/contraindication olanzapine
Age Restriction	
Prescriber Restriction	Administered under the supervision of a healthcare provider who will monitor vital signs and alertness to prevent falls or syncope (most likely PES, hospital, IMD)
Other Restriction	
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Fanapt **Iloperidone**
Covered Uses	All medically accepted indications
Required Medical Information	Documentation required to indicate that patient has tried and failed two trials formulary antipsychotics
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #60/30DS
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Adasuve **Loxapine Inhalation**
Covered Uses	All medically accepted indications
Required Medical Information	Documentation required to indicate enrollment into Adasuve REMS Program
Age Restriction	
Prescriber Restriction	
Other Restriction	One dose per 24 hours
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Caplyta **Lumateperone**
Covered Uses	All medically accepted indications
Required Medical Information	Documentation required to indicate that patient has tried and failed two trials formulary antipsychotics
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #30/30DS
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Zyprexa Injectable, Oral solution, Zydis **Olanzapine Injectable, ODT, Oral solution**
Covered Uses	All medically accepted indications
Required Medical Information	ODT or oral solution: unable to tolerate or noncompliant with oral tablet, approve up to 12 months Injectable: unable to tolerate or noncompliant with oral formulations, approve up to 3 months BRAND: tried and failed generic, approve up to 12months Zelprev: Non-formulary, not approvable. Consult with medical director
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #30/30DS *(all strengths EXCEPT 15mg)* QL = #60/30DS *(15mg)* May override QL during titration for up to 3 months
Coverage Duration	Approved for ODT(QL), Brand (QL), oral solution, all strengths up to12 months; Approved for Injectable, QL up to 3 months
Other Criteria	

Drug Name Brand Generic	 Lybalvi **Olanzapine and Samidorphan**
Covered Uses	All medically accepted indications
Required Medical Information	ALL criteria below must be met: • FDA approved indications prescribed by psychiatrist • Not on any opioid medications and no known opioid use disorder • Trial of 2 generic atypical antipsychotics with lower weight gain risk, such as Aripiprazole • Trial of naltrexone or metformin for weight control during antipsychotic therapy
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = #30/30DS, with max dose 20 mg olanzapine/10 mg samidorphan a day
Coverage Duration	Approved up to 12 months
Other Criteria	

Drug Name Brand Generic	 Invega ER Oral **Paliperidone ER**
Covered Uses	All medically accepted indications
Required Medical Information	Invega oral: documentation required to indicate patient has tried and failed oral Risperidone BRAND: tried and failed generic, approve up to 12months Invega Sustenna/Trinza: see separate approval criteria
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Invega Hafyera **Paliperidone Long-Acting Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	History of noncompliance with oral antipsychotics or difficulty in swallowing oral medications AND monthly paliperidone LAI (Invega Sustenna) has been established at least 4 months OR quarterly paliperidone LAI (Invega Trinza) has been established for one three-month cycle
Age Restriction	
Prescriber Restriction	Psychiatrist
Other Restriction	QL = 1,092 mg/182DS or QL = 1,560 mg/182DS
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Erzofri **Paliperidone Palmitate ER Injectable Suspension**
Covered Uses	All medically accepted indications
Required Medical Information	Tried and failed oral Paliperidone or Risperidone
Age Restriction	18 years or older
Prescriber Restriction	
Other Restriction	351 mg dose = 1.5ml/28DS
Coverage Duration	Approved for all strengths up to 12 months
Other Criteria	

Drug Name Brand Generic	 Risperdal M-tab or Oral solution **Risperidone ODT or Oral solution**
Covered Uses	All medically accepted indications
Required Medical Information	ODT or oral solution: unable to tolerate or noncompliant with oral tablet Brand: tried and failed generic Risperdal Consta: see separate approval criteria
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Perseris **Risperidone Subcutaneous Long-Acting Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	History of noncompliance with oral antipsychotics or difficulty in swallowing oral medications
Age Restriction	
Prescriber Restriction	
Other Restriction	QL = 90mg or 120mg per 28DS
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Uzedy **Risperidone Subcutaneous Long-Acting Injectable**
Covered Uses	All FDA approved indications
Required Medical Information	Patient has tried and failed oral antipsychotic therapy Or Transferred from hospital/facility/another provider stabilized on this medication
Age Restriction	Adults Only
Prescriber Restriction	
Other Restriction	QL = #1/30DS for 50mg, 75mg, 100mg, 125mg #1/60DS for 150mg, 200mg, 250mg
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Geodon **Ziprasidone**
Covered Uses	All medically accepted indications
Required Medical Information	Oral solution: unable to tolerate or noncompliant with oral tablet, approve up to 12 months Brand Ziprasidone: tried and failed generic Injectable: unable to tolerate or noncompliant with oral formulations, approve up to 3 months
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for Oral solution, all strengths brand, up to 12 months Approved for Injectable for up to 3 months
Other Criteria	

ANXIOLYTICS

Drug Name Brand Generic	 Xanax **Alprazolam**
Covered Uses	All medically accepted indications
Required Medical Information	1. Patient has tried and failed, has an allergic reaction or contraindication to Step 2 medications (see Alternatives to Benzodiazepines, pg 32), AND 2. Patient has tried and failed formulary benzodiazepines Lorazepam and Clonazepam.
Age Restriction	
Prescriber Restriction	
Other Restriction	Approved up to FDA Max dose
Coverage Duration	Approved for up to 12 months
Other Criteria	See Benzodiazepines Guidelines Obtain CURES report

Drug Name Brand Generic	 Xanax XR **Alprazolam XR**
Covered Uses	All medically accepted indications
Required Medical Information	1. Patient has tried and failed Step 2 medications (see Alternatives Benzodiazepines, pg 32), AND 2. Patient has tried and failed formulary Lorazepam and Clonazepam, AND 3. Patient has responded to generic Alprazolam in the past and demonstrates noncompliance, side effects, intolerance to generic Alprazolam.
Age Restriction	
Prescriber Restriction	
Other Restriction	Approved up to FDA Max dose
Coverage Duration	Approved for up to 12 months
Other Criteria	See Benzodiazepines Guidelines Obtain CURES report

Drug Name Brand Generic	 Valium **Diazepam**
Covered Uses	All medically accepted indications
Required Medical Information	1. Patient has tried and failed, has an allergic reaction or contraindication to Step 2 medications (see Alternatives Benzodiazepines, pg 32), AND 2. Patient has tried and failed formulary benzodiazepines Lorazepam and Clonazepam.
Age Restriction	
Prescriber Restriction	
Other Restriction	Approved up to FDA Max dose
Coverage Duration	Approved for up to 12 months
Other Criteria	See Benzodiazepines Guidelines Obtain CURES report

Drug Name Brand Generic	 Ativan Injectable **Lorazepam Injectable**
Covered Uses	All medically accepted indications
Required Medical Information	Patient unable to take oral form of this medication
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 3 months
Other Criteria	

ALTERNATIVES to BENZODIAZEPINES

Treatment of Insomnia[1] and Anxiety Disorders

The use of Benzodiazepines (BZ) should be considered last resort after all other non-BZ treatments have been tried. Please see BHRS Benzodiazepines Guidelines for additional information.
Below are ALTERNATIVE steps to consider in the treatment of insomnia and anxiety disorders.

Step 1: No medications

- Sleep hygiene: Walks after dinner, warm milk, warm bath or shower, quiet environment, soothing music…
- Cognitive behavioral therapy, yoga, meditation, relaxation breathing techniques…

Step 2: Medications with no known abuse potential

Insomnia[1] (see flow chart on page 2 *Alternatives to Benzodiazepines*, with alternatives to benzodiazepine receptor agonists):

- Trazodone[2] usually 25-50mg q HS, but up to 100-200mg
- Hydroxyzine or Diphenhydramine usually 25-50mg q HS, but up to 100-150mg
- TCA such as Amitriptyline or Doxepin 10-50mg q HS
- Melatonin[3] 0.3 – 5mg q HS, or Ramelteon 8mg q HS

Anxiety Disorders or Depression with Anxiety sx should consider monotherapy or combination of

- SSRIs, SNRIs, Buspirone, Clonidine, Mirtazapine, Trazodone, Bupropion, TCAs.

HYPNOTICS

Drug Name Brand Generic	 Quviviq **Daridorexant**
Covered Uses	FDA approved indications
Required Medical Information	Adults with diagnosis of Insomnia: Tried and failed 3 formulary agents
Age Restriction	18 years of age or older
Prescriber Restriction	
Other Restriction	QL = #30/30 days
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Dayvigo **Lemborexant**
Covered Uses	FDA approved indications
Required Medical Information	Documentation required to indicate that patient has tried and failed at least 3 formulary agents
Age Restriction	18 years of age or older
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Belsomra **Suvorexant**
Covered Uses	FDA approved indications
Required Medical Information	Documentation required to indicate that patient has tried and failed at least 3 formulary agents
Age Restriction	18 years of age or older
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	**Non-Formulary** Hetlioz **Tazimelteon**
Covered Uses	FDA approved indications
Required Medical Information	All of the conditions have to be met for approval: • Patient is completely blind, AND • Patient has a diagnosis of non-24-hour sleep-wake disorder by a sleep specialist or in consult with a sleep specialist, AND • Tried and failed least 1-month trial of melatonin administration that resulted in an inadequate response or an adverse effect, AND • Tried and failed least 1-month trial of ramelteon administration that resulted in an inadequate response or an adverse effect
Age Restriction	18 years of age or older
Prescriber Restriction	Sleep specialist or in consultation with sleep specialist
Other Restriction	QL #30/30DS
Coverage Duration	Approved for up to 6 months
Renewal Criteria	Documented improvement Approved for up to 12 months

Drug Name Brand Generic	 Ambien CR **Zolpidem Controlled Release**
Covered Uses	FDA approved indications
Required Medical Information	Documentation required to indicate that patient has tried and failed at least two trials of hypnotics, including immediate-release Zolpidem
Age Restriction	18 years of age or older
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 12 months
Other Criteria	

MISCELLANEOUS AGENTS

Drug Names Brand Generic	 Brixadi, Sublocade **Buprenorphine Long-Acting Subcutaneous Injection**
FDA indication	Treatment of moderate to severe OUD in patients who have initiated treatment with a single dose of transmucosal buprenorphine or are already on buprenorphine
Required Medical Information for review	
Age Restriction	18 years or older
Prescriber Restriction	
Other Restriction	#1/28DS on monthly injections
Coverage Duration	Approved for up to 12 months
Appeal	

Drug Names Brand Generic	**Non-Formulary** Deplin **L-MethylFolate**
FDA indication as Medical Food	For the distinct nutritional requirements of patients who have suboptimal L-Methylfolate levels in the cerebrospinal fluid, plasma, and/or red blood cells and have major depressive disorder with emphasis as adjunctive support for individuals who are on an antidepressant; for the distinct nutritional requirements of patients who have or are at risk for hyperhomocysteinemia and have schizophrenia who present with negative symptoms and/or cognitive impairment, with emphasis as an adjunctive support for individuals who have stabilized on antipsychotics
Required Medical Information for review	MDD: Homozygous for the T allele of the C677T polymorphism in the MTHFR gene Schizophrenia: Homozygous for the T allele of the C677T polymorphism in the MTHFR gene and Homocysteine level > 15 µmol/L
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Not a covered benefit with HSPM
Appeal	To be reviewed by BHRS and HPSM medical directors

Drug Name Brand Generic	 Nuvigil, Provigil **Armodafinil, Modafinil**
Covered Uses	FDA-approved indications; Off-label uses in ADHD, Major Depression
Required Medical Information	If ADHD: Patient tried and failed two trials of stimulants or formulary ADHD medications If Major Depression: Patient tried and failed 4 trials of antidepressants
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	

Drug Name Brand Generic	 Opvee **Nalmefene**
Covered Uses	FDA-approved indications
Required Medical Information	
Age Restriction	12 years old and older
Prescriber Restriction	
Other Restriction	Requires prescription
Coverage Duration	Approved for up to 12 months
Other Criteria	

Drug Name Brand Generic	**Non-Formulary** Nuplazid **Pimavanserin**
FDA indication	Parkinson's Disease Psychosis
Required Medical Information for review	Documentation indicating treatment with Quetiapine has been ineffective, intolerable or contraindicated Consideration of Clozapine
Age Restriction	FDA approved for adults
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for up to 12 months
Renewal requirement	Description of clinical improvement by Prescriber

Drug Name Brand Generic	 Topamax ER **Topiramate ER or Sprinkle**
Covered Uses	All medically accepted indications *Off label: alcohol dependence, anxiety disorders, eating disorder, impulse-control disorders, psychotropic-induced wt. gain, obesity *Other diagnosis: Patient must have tried and failed two formulary agents
Required Medical Information	Patient must have tried and failed formulary generic Topiramate formulations or have intolerance or contraindication to formulary generic Topiramate formulations
Age Restriction	
Prescriber Restriction	
Other Restriction	
Coverage Duration	Approved for all strengths for up to 12 months
Other Criteria	Ref: Essentials Clin Psychopharm,3rd ed

VMAT2 INHIBITORS

Drug Name Brand Generic	**Non-Formulary** Austedo **Deutetrabenazine**
FDA indication	All FDA approved indications
Required Medical Information for review	ALL the following: 1. Baseline AIMS score 2. LFTs within 6 months 3. QT status 4. Assessment of suicidality or violent behaviors 5. Full list of concurrent medications to assess drug interactions
Age Restriction	Tablets: 18 years of age or older
Prescriber Restriction	Psychiatrists or neurologists
Other Restriction	QL #120/30DS 12mg = #60/30DS
Coverage Duration	Initial: 3 months. Continuing therapy: 12 months
Other Criteria	For renewal: ALL the following: 1. Repeat AIMS demonstrating improvement 2. Information to demonstrate clinical improvement

Drug Name Brand Generic	 Austedo XR **Deutetrabenazine**
FDA indication	All FDA approved indications
Required Medical Information for review	ALL the following: 1. Baseline AIMS score 2. LFTs within 6 months 3. QT status 4. Assessment of suicidality or violent behaviors 5. Full list of concurrent medications to assess drug interactions
Age Restriction	Tablets: 18 years of age or older
Prescriber Restriction	Psychiatrists or in consult with neurologist
Other Restriction	QL = up to 48mg per day
Coverage Duration	Initial therapy: 3 months Continuing therapy: 12 months
Renewal requirement	For renewals, ALL the following: 1. Repeat AIMS demonstrating improvement 2. Information to demonstrate clinical improvement

Drug Name Brand Generic	 Ingrezza **Valbenazine**
FDA indication	All FDA approved indications
Required Medical Information for review	Trial and failure (i.e., inadequate response) of Ingrezza and ALL the following: 1. Baseline AIMS score 2. LFTs within 6 months 3. QT status
Age Restriction	Tablets: 18 years of age or older
Prescriber Restriction	Psychiatrists or in consult with neurologist
Other Restriction	QL #30/30DS
Coverage Duration	3 months
Renewal requirement	For renewals, ALL the following: 1. Repeat AIMS demonstrating improvement 2. Information to demonstrate clinical improvement

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