AETNA BETTER HEALTH®

Non-Formulary Prior Authorization guideline for Long-Acting Injectable Antipsychotics

Drugs Covered

- Invega Sustenna
- Invega Trinza
- Risperdal Consta
- Abilify Maintena
- Zyprexa Relprevv

Authorization guidelines

Non-formulary approval is authorized for members who:

- Are at least 18 years of age
- Prescribed by or in consultation with a psychiatrist
- Have received the recommended oral dosage (per FDA approved labeling) to confirm tolerability and efficacy prior to receiving the long-acting injectable medication
- Will not receive concomitant oral antipsychotics after the initial overlap period (per FDA approved labeling)
- Are not taking a CYP3A4 inducer (Abilify only)
- Have an FDA approved indication:
    - Invega Sustenna/Trinza: schizophrenia or schizoaffective disorder
    - Risperdal Consta: schizophrenia or bipolar I
    - Abilify Maintena: schizophrenia
    - Zyprexa Relprevv: schizophrenia
- Non-adherence to oral antipsychotic medications which places the patient at risk for poor outcomes

Additional Information:

These products are NOT covered for members with the following criteria:

- Use not approved by the FDA; **AND**
- The use is unapproved and not supported by the literature or evidence as an accepted off-label use.

Approval Duration: Indefinite

Medically Necessary — A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member's family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.

References:

1. Risperidal Consta [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; Revised 4/2014
2. Invega Sustenna [package insert]. Titusville, NJ: Janssen Pharmaceuticals, Inc; Revised 11/2014
3. Abilify Maintena [package insert]. Tokyo. Japan: Otsuka Pharmaceutical Co., Ltd.:12/2014
4. Zyprexa Relprevv [package insert]. Indianapolis, IN: LillyUSA, LLC: Revised 12/19/2014
5. Kishimoto T, Robenzadeh A, Leucht C, et al. Long-acting injectable vs oral antipsychotics for relapse prevention in schizophrenia: a meta-analysis of randomized trials. Schizophr Bull. 2014; 40 (1):192-213.