# Pharmacy Medical Necessity Guidelines: Antipsychotic Medications

*Effective: February 1, 2026*

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|---|---|---|---|
| Prior Authorization Required | √ | Type of Review – Care Management | |
| Not Covered | | Type of Review – Clinical Review | √ |
| Pharmacy (RX) or Medical (MED) Benefit | RX | Department to Review | RXUM |
| These pharmacy medical necessity guidelines apply to the following:<br>☒ Tufts Health RITogether – A Rhode Island Medicaid Plan | | **Fax Numbers:**<br>RXUM: 617.673.0939 | |

**Note:** This guideline does not apply to Medicare Members (includes dual eligible Members).

## OVERVIEW

The approval of generic atypical antipsychotic agents has created an opportunity to improve the cost-effectiveness of treatment and lower prescription costs for patients without compromising efficacy. A logical and evidence-based method must be employed to support and encourage adequate care. A step algorithm provides one such manner by which treatment for bipolar disorder and schizophrenia can be delivered to efficiently improve patient outcomes and control escalating healthcare expenditures.

| Drug Name | Generic Name | Utilization Management (UM) |
|---|---|---|
| Aripiprazole tablet | aripiprazole | QL |
| Abilify Maintena, aripiprazole ODT, aripiprazole oral solution | aripiprazole | PA |
| Abilify MyCite tablet with sensor | aripiprazole | PA; QL |
| Aristada | aripiprazole lauroxil | PA |
| Saphris SL tablets | asenapine | PA; QL |
| Secuado transdermal patch | asenapine | PA |
| Rexulti | brexpiprazole | PA; QL |
| Vraylar | cariprazine | PA |
| Chlorpromazine tablets | chlorpromazine | Covered |
| Clozapine tablets | clozapine | Covered |
| Clozapine orally disintegrating tablets | Clozapine | QL |
| Fluphenazine injection, oral concentrate, elixir, tablets | fluphenazine | Covered |
| Haloperidol injection, IM solution, oral concentrate, tablets | haloperidol | Covered |
| Fanapt tablets, titration pack | iloperidone | PA; QL |
| Loxitane capsules | loxapine | Covered |
| Caplyta capsules | lumateperone | PA;QL |
| Latuda tablets | lurasidone | PA; QL |
| Nuplazid tablets | pimavanserin | PA |
| Olanzapine intramuscular injection | olanzapine | Covered |
| Olanzapine ODT, tablets | olanzapine | QL |
| Zyprexa Relprevv | olanzapine | PA |
| Lybalvi tablets | Olanzapine/ samidorphan | PA; QL |
| Invega tablets, Sustenna | paliperidone | PA |
| Perphenazine tablets | perphenazine | Covered |
| Perseris prefilled suspension | risperidone | PA |
| Prochlorperazine injection, tablets, suppositories | prochlorperazine | Covered |
| Quetiapine tablets | quetiapine | QL |
| Quetiapine extended-release | quetiapine extended-release | PA; QL |

| Drug Name | Generic Name | Utilization Management (UM) |
|---|---|---|
| Risperdal Consta | risperidone | PA |
| Risperidone ODT, oral solution, tablets | risperidone | QL |
| Thioridazine tablets | thioridazine | Covered |
| Thiothixene capsules | thiothixene | Covered |
| Trifluoperazine tablets | trifluoperazine | Covered |
| Ziprasidone capsules, Geodon injection | ziprasidone | QL |

## COVERAGE GUIDELINES

The plan may authorize coverage of an antipsychotic medication requiring prior authorization when **ALL** of the following criteria are met:

1. The member is stabilized on the medication

**OR**

2. The member was recently started on the requested medication in an acute care setting, residential setting, or partial hospital setting

**OR**

3. One of the following drug-specific criteria:

**Aripiprazole orally disintegrating tablet (ODT) and oral solution**

1. Member has a diagnosis of schizophrenia, bipolar disorder, autistic disorder, depression, or Tourette's syndrome

**AND**

2. Member has difficulty swallowing and is therefore unable to administer aripiprazole tablet

**Abilify Maintena (aripiprazole)**

1. Member tried and failed therapy with or the provider indicates clinical inappropriateness of or non-compliance with at least one oral alternative atypical antipsychotic (e.g., aripiprazole, risperidone, olanzapine)

**Abilify MyCite (aripiprazole tablet with sensor)**

1. The Member is 18 years of age or older

**AND**

2. The Member has one of the following diagnoses:
   a) Bipolar disorder
   b) Schizophrenia
   c) Major depressive disorder

**AND**

3. Member has a history of poor adherence (<80%) with at least two oral second generation antipsychotics, one of which must be aripiprazole

**AND**

4. Documentation that the low medication adherence with aripiprazole was not related to an inadequate response, intolerance, or adverse effect

**AND**

5. Documentation that the Member has experienced worsening symptoms due to lack of adherence with oral second-generation antipsychotics

**AND**

6. Documentation that the Member has attempted all of the following strategies to improve adherence:
   a) Use of pillboxes
   b) Setting reminder alarms
   c) Coordinating the administration time with that of other daily medications

**AND**

7. Documentation of a comprehensive treatment plan that will incorporate the data from the mobile application/web-based portal to monitor the Member's treatment

**Aristada (aripiprazole lauroxil), Aristada Initio**

1. The Member tried and failed therapy with or the provider indicates clinical inappropriateness of or non-compliance with at least one oral alternative atypical antipsychotic (e.g., aripiprazole, risperidone, olanzapine)

**Caplyta (lumateperone)**

1. The Member has a diagnosis of schizophrenia or bipolar disorder

**AND**

2. The Member has had an inadequate response or adverse reaction to at least two alternative atypical antipsychotics or the Member has a contraindication to all alternative atypical antipsychotics

**OR**

1. The Member has a diagnosis of major depressive disorder

**AND**

2. The Member has had an inadequate response or adverse reaction to at least two antidepressant medications from two different therapeutic classes

**Fanapt (iloperidone)**

1. The Member has a diagnosis of bipolar disorder or schizophrenia

**AND**

2. The Member has an inadequate response or adverse reaction to at least two alternative atypical antipsychotics, one of which must be risperidone, or a contraindication to all alternative atypical antipsychotics

**Invega Sustenna (paliperidone) injection and Invega Trinza (paliperidone) injection**

1. The Member has tried and failed therapy with, or the provider indicates a clinical inappropriateness of or non-compliance with at least one oral alternative atypical antipsychotic (e.g., aripiprazole, risperidone, olanzapine)

**Lybalvi (olanzapine/samidorphan) tablet**

1. The member has a diagnosis of schizophrenia or bipolar disorder

**AND**

2. The Member is 18 years of age or older

**AND**

3. The Member has had an inadequate response or adverse reaction to **two** atypical antipsychotics, or a contraindication to all alternative generic atypical antipsychotics

**Nuplazid (pimavanserin)**

1. Documented diagnosis of hallucinations and delusions associated with Parkinson's disease psychosis.

**AND**

2. The prescribing physician is a neurologist or a psychiatrist

**AND**

3. Member has had an inadequate response, adverse reaction, or contraindication to quetiapine

**Paliperidone extended-release tablets**

1. The Member has a diagnosis of schizophrenia

**AND**

2. The Member has had an inadequate response or adverse reaction to at least two alternative atypical antipsychotic agents, one of which must be risperidone, or a contraindication to all alternative atypical antipsychotics

**Pimozide**

1. The member had an inadequate response or adverse reaction to at least two alternative antipsychotic agents or contraindication to all alternative antipsychotics

**Perseris (risperidone injection)**

1. The Member tried and failed therapy with or the provider indicates clinical inappropriateness of or non-compliance with at least one oral alternative atypical antipsychotic (e.g., aripiprazole, risperidone, olanzapine)

**Rexulti (brexpiprazole)**

1. The Member has a diagnosis of schizophrenia

**AND**

2. The Member has had an inadequate response or adverse reaction to at least two alternative atypical antipsychotic agents, one of which must be aripiprazole, or a contraindication to all alternative atypical antipsychotics

**OR**

1. The Member has a diagnosis of major depressive disorder

**AND**

2. The Member had had an inadequate response or intolerance to at least two antidepressant medications from two different therapeutic classes

**OR**

1. The Member has a diagnosis of dementia due to Alzheimer's disease **AND** is being treated for agitation

**Risperdal Consta (risperidone injection)**

1. The Member tried and failed therapy with or the provider indicates clinical inappropriateness of or non-compliance with at least one oral alternative atypical antipsychotic (e.g., aripiprazole, risperidone, olanzapine)

**Asenapine, Lurasidone**

1. The Member has a diagnosis of bipolar disorder or schizophrenia

**AND**

2. The Member has had an inadequate response or adverse reaction to at least two alternative atypical antipsychotic agents, or contraindication to all alternative atypical antipsychotic agents

**Secuado (asenapine patch)**

1. The Member has a diagnosis of schizophrenia

**AND**

2. The Member has had an inadequate response or adverse reaction to at least two alternative atypical antipsychotic agents, or a contraindication to all alternative atypical antipsychotic agents

**AND**

3. The Member tried and failed therapy with or the provider indicates clinical inappropriateness of therapy with asenapine tablet.

**Quetiapine extended-release**

1. For the diagnosis of schizophrenia or bipolar disorder
   a) The Member has a diagnosis of schizophrenia or bipolar disorder

   **AND**

   b) The Member has had an inadequate response or adverse effect to a trial with quetiapine immediate-release (IR), or the provider indicates the Member is at increased risk for adverse clinical outcome with the use of quetiapine IR
2. For the diagnosis of depression,
   a) The Member has a diagnosis of depression

   **AND**

   b) Documentation quetiapine extended-release will be used as adjunctive therapy in conjunction with an antidepressant medication

   **AND**

   c) The Member has had an inadequate response or adverse reaction to at least three antidepressant medications, or the provider indicates clinical inappropriateness of therapy with alternative antidepressant medications

**Vraylar (cariprazine)**

1. The Member has a diagnosis of bipolar disorder or schizophrenia

**AND**

2. The Member has had an inadequate response or adverse reaction to at least two alternative atypical antipsychotic agents, or a contraindication to all alternative atypical antipsychotics

**OR**

1. The Member has a diagnosis of major depressive disorder

**AND**

2. The Member has had an inadequate response or adverse reaction to at least two generic antidepressants or the provider indicates clinical inappropriateness of therapy with all antidepressants

**Zyprexa Relprevv (olanzapine injection)**

1. The Member tried and failed therapy with or the provider indicates clinical inappropriateness of treatment with at least two atypical antipsychotics, one of which must be oral olanzapine.

## LIMITATIONS

1. The following quantity limitations apply:

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|---|---|
| Aripiprazole tablet, orally disintegrating tablet | 1 tablet per day |
| Aripiprazole oral solution | 25 mL per day |
| Caplyta (lumateperone) | 1 capsule per day |
| Fanapt (iloperidone) | 2 tablets per day |
| Invega (paliperidone) | 1 tablet per day |
| Latuda (lurasidone) | 1 tablet per day |
| Lybalvi (olanzapine/samidorphan) | 1 tablet per day |
| Nuplazid (pimavanserin) 10 mg, 17 mg tablets | 2 tablets per day |
| Nuplazid (pimavanserin) 34 mg tablets | 1 tablet per day |
| Rexulti (brexpiprazole) | 1 tablet per day |
| Saphris (asenapine) | 2 tablets per day |
| Secuado (asenapine) | 1 patch per day |
| Seroquel XR (quetiapine) 50 mg, 300 mg, 400 mg | 2 tablets per day |
| Seroquel XR (quetiapine) 150 mg, 200 mg | 1 tablet per day |

2. Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria.
3. Samples, free goods, or similar offerings of the requested medication do not qualify for an established clinical response or exception, but will be considered on an individual basis for prior authorization.

## CODES

None

## REFERENCES


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2. Abilify Maintena (aripiprazole) [prescribing information]. Rockville, MD: Otsuka Pharmaceuticals; June 2020.
3. Abilify MyCite (aripiprazole tablets with sensor) [prescribing information]. Rockville, MD: Otsuka Pharmaceuticals; February 2023.
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6. Aristada Initio (aripiprazole lauroxil extended-release) [prescribing information]. Waltham, MA; Alkermes, Inc.; December 2023.
7. Caplyta (lumateperone) [prescribing information]. New York, NY: Intra-Cellular Therapies, Inc; November 2025.
8. Fanapt (iloperidone) [prescribing information]. Washington, D.C.: Vanda Pharmaceuticals Inc.; April 2024.
9. Invega (paliperidone) [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; March 2022.
10. Invega Sustenna (paliperidone) [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals, Inc.; July 2022.
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12. Kay SR, Fiszbein A, Opler LA. The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophr Bull*. 1987;13(2):261-76.
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16. Lybalvi (olanzapine/samidorphan) [prescribing information]. Waltham, MA: Alkermes, Inc; January 2024.

17. Nuplazid (pimavanserin) [prescribing information]. San Diego, CA: ACADIA Pharmaceuticals, Inc; November 2020.
18. Pimozide [prescribing information]. Chestnut Ridge, NY: Par Pharmaceutical; March 2017.
19. Perseris (risperidone) [prescribing information]. North Chesterfield, VA: Indivior, Inc; December 2022.
20. Rexulti (brexpiprazole) [prescribing information]. Rockville, MD: Otsuka Pharmaceuticals; May 2023.
21. Risperdal Consta (risperidone) [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals, Inc; February 2021.
22. Saphris (asenapine) [prescribing information]. Madison, NJ: Allergan USA; October 2021.
23. Secuado (asenaprine) [prescribing information]. Miami, FL: Noven Therapeutics, LLC; December 2023.
24. Seroquel XR (quetiapine extended-release) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; January 2022.
25. Vraylar (cariprazine) [prescribing information]. North Chicago, IL: AbbVie Inc.; January 2024.
26. Zyprexa Relprevv (olanzapine) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; December 2023.

## APPROVAL HISTORY

October 11, 2022: Reviewed by Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. April 11, 2023: Effective May 1, 2023, updated Vraylar criteria to include new indication of major depressive disorder. Updated Rexulti criteria for major depression to remove requirement that member step through two antipsychotics.
2. July 11, 2023: Effective August 1, 2023, updated Rexulti criteria to include expanded indication of treatment of agitation associated with dementia due to Alzheimer's disease.
3. May 14, 2024: Effective August 1, 2024, updated RxUM fax number. Updated Fanapt criteria to include new indication of bipolar disorder. Updated previous trial language throughout the MNG.
4. May 13, 2025: No changes
5. December 9, 2025: Effective February 1, 2026, updated Caplyta criteria to include expanded indication for the treatment of major depressive disorder.

## BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.