Harvard Pilgrim Health Care | TUFTS Health Plan

Pharmacy Medical Necessity Guidelines: **Antipsychotics Medications**

Effective: January 13, 2026

Guideline Type	☐ Prior Authorization ☐ Non-Formulary ☒ Step-Therapy ☐ Administrative

Applies to:

Commercial Products

☒ Harvard Pilgrim Health Care Commercial products; Fax: 617-673-0988

☒ Tufts Health Plan Commercial products; Fax: 617-673-0988

Public Plans Products

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax: 617-673-0988

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to ensure that prior authorization has been obtained.

Overview

Food and Drug Administration – Approved Indications

Rexulti (brexpiprazole) is indicated for use as an adjunctive therapy to antidepressants for the treatment of major depressive disorder (MDD) in adults, and for the treatment of schizophrenia in adults and pediatric patients ages 13 years and older, and for the treatment of agitation associated with dementia due to Alzheimer's disease

Vraylar (cariprazine) is indicated for treatment of schizophrenia in adults, acute treatment of manic or mixed episodes associated with bipolar I disorder in adults, and treatment of depressive episodes associated with bipolar I disorder (bipolar depression) in adults, and for adjunctive therapy to antidepressants for the treatment of major depressive disorder (MDD) in adults

Paliperidone extended-release tablets are indicated for the treatment of schizophrenia, and for the treatment of schizoaffective disorder as monotherapy and an adjunct to mood stabilizers and/or antidepressant therapy

Cobenfy (xanomeline and trospium chloride) is indicated for the treatment of schizophrenia in adults.

Clinical Guideline Coverage Criteria

Note: Prescriptions that meet the initial step therapy requirements will adjudicate **automatically** at the point of service. If the patient does not meet the initial step therapy criteria, the prescription will deny at the point of service with a message indicating that prior authorization (PA) is required. Refer to the Coverage Criteria below and submit PA requests to the plan for patients who do not meet the step therapy criteria at the point of service.

Please refer to the table below for paliperidone extended-release tablets subject to this policy:

Drug	Coverage
Step-1	
aripiprazole	Covered
clozapine	
lurasidone	
olanzapine	
quetiapine IR/ER	
risperidone	
ziprasidone	
Step-2	
paliperidone ER tablets	Requires prior use of one drug on Step-1

Automated Step Therapy Coverage Criteria for Paliperidone ER tablets

The following stepped approach applies to coverage of Paliperidone ER tablets by the plan:

Step 1: Medications on Step-1 are covered without prior authorization

Step 2: The plan may cover Step-2 medications if the following criteria are met:

a) The patient has had a trial of one (1) Step-1 or the requested Step-2 medication as evidenced by a previous paid claim under the prescription benefit administered by the plan.

Coverage Criteria for Patients not meeting the Automated Step Therapy Coverage Criteria at the Point of Sale

Step 2: The plan may cover Paliperidone ER tablets on Step-2 if the following criteria are met:

1. The patient has had a trial of one Step-1 or the requested Step-2 medication as evidenced by physician's documented use, excluding the use of samples

OR

2. The patient has a physician documented trial and failure with one, or contraindication or intolerance to all of the step 1 medications

OR

3. Patient was recently started on the requested medication in an acute care setting, residential setting, or partial hospital setting

OR

4. Patient lives in or the prescribing provider's office is located in Maine

Please refer to the table below for Vraylar and Rexulti subject to this policy:

Drug	Premium Formulary Coverage
Step-1	
aripiprazole	Covered
asenapine	
clozapine	
iloperidone	
lurasidone	
olanzapine	
quetiapine IR/ER	
risperidone	
ziprasidone	
Step-2	
Rexulti	Requires prior use of two drugs on Step-1
Vraylar	

Automated Step Therapy Coverage Criteria for Vraylar and Rexulti

The following stepped approach applies to coverage of the Step-2 medications by the plan:

Step 1: Medications on Step-1 are covered without prior authorization

Step 2: The plan may cover Step-2 medications if the following criteria are met:

a) The patient has had a trial of at least two (2) Step-1 or the requested Step-2 medication as evidenced by a previous paid claim under the prescription benefit administered by the plan.

Coverage Criteria for Patients not meeting the Automated Step Therapy Coverage Criteria at the Point of Sale

Step 2: The plan may cover Vraylar and Rexulti on Step-2 if one the following criteria are met:

1. The patient has had a trial of two Step-1 or the requested Step-2 medication as evidenced by physician's documented use, excluding the use of samples

OR

2. The patient has a physician documented trial and failure with at least two, or contraindication or intolerance to all of the step 1 medications

OR

3. Patient was recently started on the requested medication in an acute care setting, residential setting, or partial hospital setting

OR

4. Patient lives in or the prescribing provider's office is located in Maine

OR

5. The request is for Rexulti used for management of agitation associated with dementia due to Alzheimer's disease

Cobenfy (xanomeline and trospium chloride) Prior Authorization Criteria

The plan may authorize coverage of **Cobenfy (xanomeline and trospium chloride)** when the following criteria are met:

1. Member has a diagnosis of schizophrenia

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

Limitations

1. The Step Therapy Program for Vraylar and Rexulti applies to Premium Formulary Only.
2. Rexulti and Vraylar are non-formulary on Value and NHCore formularies.
3. The Step Therapy Program for Paliperidone ER tablets applies to all Commercial and Direct formularies.
4. Cobenfy PA criteria applies to all Commercial and Direct formularies.
5. For a non-formulary medication request, please refer to the Pharmacy Medical Necessity Guidelines for Formulary Exceptions and submit a formulary exception request to the plan as indicated.
6. 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

1. Rexulti (brexpiprazole) [prescribing information]. Rockville, MD: Otsuka America Pharmaceutical Inc; June 2025.
2. Vraylar (cariprazine) [prescribing information]. Madison, NJ: Allergan USA Inc; November 2024.
3. Paliperidone ER tablets [prescribing information]. Bridgewater, NJ: Amneal Pharmaceuticals LLC; February 2025
4. Cobenfy (xanomeline and trospium chloride) [prescribing information]. Princeton, NJ: E.R. Squibb & Sons, L.L.C.; September 2024.

Approval And Revision History

September 13, 2022: Reviewed by the Pharmacy & Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

- June 13, 2023: Effective August 2023 added criteria for Rexulti to allow coverage for the expanded indication of agitation associated with dementia. Administrative update to the overview section to reflect expanded indication of Vraylar as an adjunctive treatment of antidepressants for MDD.
- October 10, 2023: Effective January 1, 2024, added lurasidone to the list of Step-1 agents for the paliperidone extended-release step therapy criteria.
- February 13, 2024: Effective May 1, 2024, removed criterion pertaining to patient or prescribing provider’s office is located in Rhode Island.
- January 14, 2025: Added PA coverage criteria for Cobenfy. Changed the name of the MNG from 'Antipsychotic Step Therapy Programs’ to ‘Antipsychotic Medications’.
- January 13, 2026: No clinical changes.
- February 2026: Administrative update to remove CareLink from Medical Necessity Guideline template.

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.