



STATE OF TENNESSEE  
BUREAU OF TENNCARE  
DEPARTMENT OF FINANCE AND ADMINISTRATION  
310 GREAT CIRCLE ROAD  
NASHVILLE, TENNESSEE

Dear Prescriber,

On November 1, 2005, the TennCare Preferred Drug List (PDL) will be expanded to include the Atypical Antipsychotic drug class. Table 1 indicates which drugs will be considered “preferred” drugs and which drugs will be considered “non-preferred” drugs.

Table 1

PREFERRED	NON-PREFERRED
CLOZAPINE (compares to Clozaril®) GEODON® (ziprasidone) RISPERDAL® (risperidone) SEROQUEL® (quetiapine) FAZACLO ODT® (clozapine)	ABILIFY® (aripiprazole) CLOZARIL® (clozapine) RISPERDAL M-TAB® (risperidone) RISPERDAL CONSTA® (risperidone) ZYPREXA® (olanzapine) ZYPREXA ZYDIS® (olanzapine)

There are several important points for you to be aware of:

1. With the exception of patients on low dose (25-50 mg) Seroquel, all **patients currently receiving an atypical antipsychotic will be “grandfathered” indefinitely** into the new PDL. This means that you will not be required to change to a preferred drug or demonstrate that your patient meets the criteria to receive the drug they are taking (via a prior authorization process) for patients with a current prescription for a drug in this class.
2. **All new prescriptions for atypical antipsychotics**, whether for a preferred or non-preferred drug, **will require prior authorization**. A prescription for a drug the patient is currently taking (i.e. the doctor writes a prescription for the same medicine the patient is already on, because the patient has no more refills on the prior prescription) would not be subject to prior authorization, but would instead be grandfathered as per #1 above. Prescriptions for patients who are new to therapy in this class and prescriptions that represent a change in therapy from one drug in the class to another will be subject to the prior authorization requirement. A general explanation of how to go about obtaining a prior authorization is included at the end of this document. Prior authorization (PA) criteria for the preferred atypical antipsychotics is included in Table 2.

Table 2

<b>Atypical Antipsychotic Class Criteria</b>	
<ul style="list-style-type: none"> <li>• <b>Atypical antipsychotics will be authorized for the following diagnoses:</b></li> </ul>	
<ul style="list-style-type: none"> <li>○ <b>BIPOLAR MANIA-ACUTE, BIPOLAR DEPRESSION, BIPOLAR MAINTENANCE, BIPOLAR MIXED STATES</b></li> <li>• Patients should have documented in their medical record a diagnosis of bipolar disorder.</li> <li>• For patients in a severe manic episode, one of the preferred atypical agents will be approved.</li> <li>• For partial or non-response after a 4-week trial of a preferred atypical at the highest recommended or tolerated dose, approval will be granted for an alternative preferred atypical.               <ul style="list-style-type: none"> <li>▪ Patients not on a mood stabilizer (lithium, divalproex, lamotrigine, oxcarbazepine, or carbamazepine) will be required to try addition of a mood stabilizer before an alternative preferred atypical will be approved.</li> <li>▪ Patients currently receiving a mood stabilizer will be approved for an alternative preferred atypical.</li> </ul> </li> <li>• For partial or non-response after a 4-week trial of an appropriate dose of a second preferred atypical and a mood stabilizer, a trial of clozapine should be strongly recommended to the patient if not already tried. If refused, this should be documented in the medical record, and a trial of a non-preferred atypical agent will be approved. For patients who try clozapine and experience a partial or non-response after a 4-week trial of an appropriate dose, then a non-preferred atypical agent will be approved.</li> </ul>	
<ul style="list-style-type: none"> <li>○ <b>SCHIZOPHRENIA</b></li> <li>• Patient should have documented in their medical record a diagnosis of schizophrenia or schizoaffective disorder</li> <li>• For the first episode or for patients with a history of response of positive symptoms to an antipsychotic drug, one of the preferred agents should be tried. If the patient is schizoaffective and currently in an excited state, a mood stabilizer may be used. If the patient is depressed at the end of four weeks, an antidepressant may be used.</li> <li>• If psychosis persists after a trial of 4 weeks at an appropriate dose of a preferred atypical, then a second preferred newer generation atypical should be tried as monotherapy for a period of four weeks. If schizoaffective, a mood stabilizer may be used.</li> <li>• If psychosis persists or if moderate to severe tardive dyskinesia is present despite two trials with two different drugs from the preferred list, a trial of clozapine should be strongly recommended to the patient if not already tried. Clozapine is also recommended in patients who have made a medically serious suicide attempt. If clozapine is refused, this should be documented in the medical record, and a non-preferred atypical will be approved. For patients who try clozapine and experience a partial or non-response after a 4-week trial of an appropriate dose, then a non-preferred atypical agent will be approved.</li> </ul>	
<ul style="list-style-type: none"> <li>○ <b>SCHIZOAFFECTIVE DISORDER</b></li> <li>○ <b>DELUSIONAL DISORDER</b></li> <li>○ <b>PSYCHOTIC DEPRESSION</b></li> <li>○ <b>TOURETTES/SEVERE TICS</b></li> <li>○ <b>PSYCHOTIC DISORDER NOS</b></li> <li>○ <b>AGITATION OF DEMENTIA</b></li> <li>○ <b>PSYCHOSIS SECONDARY TO A MEDICAL CONDITION</b></li> <li>○ <b>AGITATION/AGGRESSION IN MENTAL RETARDATION/AUTISM</b></li> <li>○ <b>AGGRESSION/IMPULSE CONTROL DISORDERS</b></li> <li>○ <b>BRIEF PSYCHOTIC DISORDER</b></li> <li>○ <b>SUBSTANCE-INDUCED PSYCHOTIC DISORDER (including SUBSTANCE-INDUCED WITHDRAWAL PSYCHOTIC DISORDER)</b></li> <li>○ <b>SEVERE REFRACTORY DEPRESSION</b></li> <li>○ <b>SEVERE REFRACTORY OBSESSIVE COMPULSIVE DISORDER</b></li> <li>○ <b>SEVERE REFRACTORY POST-TRAUMATIC STRESS DISORDER</b></li> </ul> <ul style="list-style-type: none"> <li>• For partial or non-response following a 4-week trial at an appropriate dose of a preferred atypical, an alternative preferred atypical will be approved.</li> <li>• For partial or non-response following a 4-week trial at an appropriate dose of the second preferred atypical, a non-preferred atypical may be approved.</li> </ul>	
<ul style="list-style-type: none"> <li>• <b>Atypical antipsychotics will also be authorized in situations where the prescriber can provide documented clinical evidence supporting the use of the requested medication for the requested indication.</b></li> </ul>	

3. **In addition to the Table 2 criteria, in order to obtain PA for a non-preferred atypical antipsychotic**, the patient must have tried and failed two courses of a preferred atypical antipsychotic or have a clinically justified reason for not being able to take a preferred atypical antipsychotic, such as a noted allergy to that medication. If the TennCare claims processing system has a record that supports the fact that these additional criteria have been met (e.g. the patient has had two previous trials of preferred atypical antipsychotics), the PA will be issued automatically (i.e. the prescriber will not have to seek the PA).

In addition to the above criteria, the following requirements must be met in order to receive approval for Risperdal M-tab®, Zyprexa Zydis®, Risperdal Consta®, or Symbyax®.

<b>† Risperdal M-tab® and Zyprexa Zydis®</b>
Risperdal M-tab® and Zyprexa Zydis® will only be authorized if the recipient is unable to swallow tablets, but is able to absorb PO medications.

<b>‡ Risperdal Consta®</b>
Risperdal Consta® will only be authorized if the recipient has documented non-compliance with PO atypicals or non-response due to non-compliance .

<b>Symbyax® (H7Z) (olanzapine/fluoxetine)</b>
All of the following must apply: <ul style="list-style-type: none"> <li>• The recipient is unable to tolerate the medications given separately</li> <li>• The diagnosis must be depressive episodes associated with bipolar disorder</li> <li>• The recipient is &gt; 18 years of age and &lt; 65 years of age</li> </ul>

4. **Patients currently on low dose (25-50 mg) Seroquel** will not be grandfathered. Prescribers will be required to seek PA and patients must meet the established criteria in order to continue receiving this drug.
5. PA will be granted for quantities up to the limits noted in Table 3. **If your patient needs a quantity in excess of the quantity limit**, you must specifically request an additional PA for a quantity in excess of the quantity limit. This can be done at the same time you request PA for coverage of the atypical antipsychotic.

Table 3

<b>Atypical Medication</b>	<b>Quantity Limit</b>
ABILIFY®	1 tablet/ day
GEODON®	2 capsules/day
RISPERDAL®	2 tablets/day or 6 mL/day
RISPERDAL M-TAB®	2 tablets/day
RISPERDAL CONSTA®	4 syringes/month
SEROQUEL®	4 tablets/day
ZYPREXA®	1 tablet/day
ZYPREXA ZYDIS®	1 tablet/day

6. Prior authorizations may be obtained from the First Health Services Clinical Call Center by calling 866-434-5524 or by fax at 866-434-5523. If you would like to obtain a prior authorization before the patient exhausts their current supply of medication, please inform the technician at the call center or note on the faxed prior authorization form that the requested prior authorization is for future use by the patient. The prior authorization form can be downloaded from the First Health/TennCare website at:  
[https://tennessee.fhsc.com/Downloads/provider/TNRx\\_PAfaxform.pdf](https://tennessee.fhsc.com/Downloads/provider/TNRx_PAfaxform.pdf)
7. **Special Safe Guard for November ONLY:**  
Due to the late notice given regarding the inclusion of atypical antipsychotic medications on the PDL, the system used to process pharmacy claims will allow pharmacists to override the requirement for prior authorization and dispense a full 31-day supply of the medication if the prescriber has not sought prior authorization in advance and the pharmacist is unable to contact the prescriber when the patient presents with the prescription in order to facilitate obtaining PA. This special provision will be in place for November only and will allow the patient and the pharmacy extended time to contact the prescriber to receive prior authorization or make a medication change. Beginning in December, the PA requirement will be in full force.