Prior Authorization Guidelines
Formulary Brand Name Long Acting Injectable Antipsychotics

**FDA Approved Indication:**

BHR has a diagnosis for which the requested medication has an approved FDA indication. These medications are not approved for use in individuals under the age of 18.

**Guidelines for Approval:**

1. BHR must demonstrate sustained clinical improvement and tolerability on the short acting form of the requested Brand Name Long Acting agent, and
2. Documentation of noncompliance on oral medications, and/or documentation supporting the benefit of long acting medication in achieving clinical stability.

**Additional Requirements:**

Prior Authorization for medications covered under this guideline will not continue beyond 60 days for members receiving oral antipsychotics concomitantly with Brand Name Long Acting Injectable Antipsychotics

Initial Prior Authorization for Abilify Maintena and Invega Sustenna will be for 6 months. Subsequent Prior Authorization frequency may be determined by the (T)RBHA, and will be contingent upon evidence of clinical efficacy and appropriate clinical monitoring.

**Coverage is Not Authorized for:**

1. Doses greater than FDA recommended maximum daily dosage without meeting prior authorization guidelines for exceeding maximum daily dosage.
2. Concomitant use of cytochrome p450 inducers (eg, carbamazepine) and Abilify Maintena
3. Individuals under the age of 18

**References:**

1. ADHS/DBHS: [Provider Manual Section 3.15: Psychotropic Medication: Prescribing and Monitoring](#)
2. Manufacturer Product Information

Finalized: 8/5/2013