Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	July 1, 2022 August 11, 2022, October 11, 2022, January 24, 2024

ANTIPSYCHOTIC NON-PREFERRED CRITERIA

LENGTH OF AUTHORIZATION: Up to one year

REVIEW CRITERIA:

- Clinical documentation of medical necessity due to the following:
  - There is not a drug on the preferred drug list to treat the disease or medical condition which is an acceptable clinical alternative
  - The alternatives have been ineffective in the treatment of the patient's disease
  - The patient has a diagnosis of schizophrenia, schizotypal or delusional disorder and meets the following:
    - prior authorization has been granted for the prescribed drug **-OR-**
    - prior authorization has been granted for a similar drug class **-AND-**
    - the prescribed medication was dispensed within the previous 12 months

    -OR-
  - Based on historic evidence and known characteristics of the patient and the preferred drug(s), the drug is likely to be ineffective or the number of doses have been ineffective.
- Medication requested must have the FDA approved indication and the patient must be within the FDA approved age limits.

Florida Medicaid Preferred Drug List:
https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/