Drug Use Research & Management Program
Oregon State University, 500 Summer Street NE, E35
Salem, Oregon 97301-1079
Phone 503-947-5220 | **Fax** 503-947-1119

Policy Evaluation: Antipsychotics in Children

Plain Language Summary:

- In children less than 6 years old, providers sometimes prescribe medicines called antipsychotics for serious behavior issues related to developmental disorders.
- Antipsychotics can cause weight gain, movement problems, and changes in hormones. Risk for side effects increases with length of therapy. Providers should regularly monitor for these side effects, and limit use to the shortest duration and lowest dose needed to improve symptoms. Because of these side effects, guidelines suggest people try other behavioral therapy before taking an antipsychotic.
- The Oregon Health Authority requires providers to explain why they are prescribing an antipsychotic to people less than 6 years of age before Oregon Health Plan (OHP) will pay for the medication. We evaluated how this policy is working and found that:
    - Only a small number of people less than 6 years old are prescribed antipsychotics.
    - Antipsychotics were prescribed most often for developmental disorders and challenging behavior.
    - Blood sugar testing occurs for about 40% of young children prescribed an antipsychotic.
    - The policy may decrease the number of people prescribed antipsychotics for longer than 30 days, but more data is needed to confirm these findings.
- We recommend continuing this policy to encourage appropriate antipsychotic use and suggest changes to decrease administrative burden.

Purpose:

The purpose of this policy evaluation is to evaluate administrative burden and changes in antipsychotic prescribing after implementation of a safety edit for children less than 6 years of age.

Research Questions:

1. For members less than 6 years of age prescribed antipsychotics, what diagnoses are present in medical claims that are potential indications for therapy?
2. For members less than 6 years of age, has duration of antipsychotic therapy changed after implementation of the policy?
3. For members less than 6 years of age prescribed antipsychotics, has the proportion of members with metabolic monitoring or with engagement of a mental health specialist changed after implementation of the policy?
4. For members less than 6 years of age prescribed antipsychotics, what proportion of members have denied claims or prior authorization requests?

Conclusions:

- This analysis identified 33 members who were less than 6 years of age and prescribed an antipsychotic in the 6 months after implementation of the policy. In the 6 months before implementation of the safety edit, 31 members were prescribed an antipsychotic. The most common diagnoses for members prescribed antipsychotics included autism spectrum disorder, attention deficit hyperactivity disorder (ADHD), and other developmental

disorders. Challenging behavior (e.g., aggressive, combative, explosive, violent or self-harmful behavior) was documented for 42% of members (n=14) during the prior authorization (PA) process.

- The most common antipsychotics prescribed to children less than 6 years of age were risperidone (58%) and aripiprazole (27%). Both risperidone and aripiprazole have an indication for irritability associated with autism for patients at least 5 and 6 years of age, respectively.
- Because of the small number of members and the short follow-up duration, it is difficult to identify whether there were changes in relevant clinical outcomes after implementation of the policy. Preliminary data do not indicate changes in glucose monitoring or the number of prescriptions written by a specialist.
    - In the 6 months before implementation of the policy, 26% of members had antipsychotic prescriptions written by a psychiatrist or neurodevelopmental pediatrician compared to 24% after implementation of the safety edit.
    - In the 6 months before implementation of the policy, 35% of members had claims for glucose monitoring compared to 39% of members in the 6 months after implementation of the safety edit. Profile review identified that 4 members (12%) had glucose monitoring only after the PA requirement.
- This policy was implemented in conjunction with a retrospective provider educational initiative in which providers were faxed information about the new policy when a member had their first paid claim for an antipsychotic. Because automated faxes were successfully sent for only 45% of members, manual efforts were made to call provider offices and send information about the policy.
    - Despite efforts to notify providers about the new policy, about half of members (n=17, 52%) with claims for an antipsychotic had an initial denied claim after implementation of the policy. Some members had subsequent denied claims after short-term approvals or when titrating doses.
- In the 6 months before implementation of the policy, 90% of members had therapy longer than 30 days compared to 73% in the 6 months after implementation of the safety edit.
    - After implementation of the safety edit, PA requests were submitted for 73% of members (n=24). The current policy applies to members less than 6 years of age, and PA was not required for 24% of members because they turned 6 years of age (n=7) before their second antipsychotic claim or had less than 30 days of therapy (n=1). Prior authorization was required, but not submitted for one member (3%).
    - Long-term therapy beyond 90 days was approved for 17 members (52%). For one member (3%) a PA was initially denied. Short-term approvals (up to 90 days) were approved for 6 members (18%). Short-term approvals were intended to avoid interruptions in ongoing care and allow providers additional time to submit information needed to meet PA requirements. Two members had a subsequent denied PA after a short-term approval.

Recommendations:

- Update the safety edit in **Appendix 1** to:
    - include assessment of rapid weight gain for members without glucose monitoring,
    - allow longer initial therapy (up to 60 days) before PA is required to minimize administrative burden, and
    - include members 6 years of age in the policy to provide monitoring for members who are turning 6 years old.
- Continue to improve provider educational initiatives to notify providers about the policy before members have a denied claim.

Background

Few antipsychotics have been studied in young children, and efficacy and safety has not been established for any antipsychotic in young children less than 5 years of age. Prior reviews evaluated by the Pharmacy & Therapeutics Committee have identified evidence that antipsychotics may improve behavior that challenges in children with autism or disruptive behavior disorders.[1] Both risperidone and aripiprazole have an indication for irritability associated with autism

(including symptoms of aggression towards others, deliberate self-injury, temper tantrums, and quickly changing moods) for patients at least 5 and 6 years of age, respectively.[2,3] These drugs also have the most evidence of benefit for disruptive behavior disorders.[1] Lurasidone has been studied in people with autism spectrum disorder, but did not demonstrate symptom improvement compared to placebo, and there is low quality evidence that quetiapine may have symptomatic and functional improvement in people with disruptive behavior disorder.[1]

Current guidelines recommend non-pharmacological therapy as first-line therapy for children prior to prescription of an antipsychotic.[4-6] Antipsychotics can be associated with significant risk of long-term adverse events. Because antipsychotics increase the risk of metabolic syndrome, laboratory monitoring is recommended before starting treatment and routinely during long-term therapy. In Medicaid, several national quality metrics aim to improve use of psychotropic medications in children. The 2023 core set of children's health care quality measures includes metabolic monitoring and use of first-line psychosocial care in children and adolescents on antipsychotics.[7]

In 2021, the Oregon Pharmacy and Therapeutic Committee recommended implementation of a safety edit to support appropriate use of antipsychotics in children 5 years of age or younger. The proposal targeted children after their first prescription in order to accommodate prescribing for urgent or acute symptoms and to avoid interruptions in therapy during transitions of care for patients newly enrolled in Medicaid. Ongoing therapy requires documentation of clinical rationale, metabolic monitoring, use of first-line non-pharmacologic therapy, and specialist consult. Upon their first claim for an antipsychotic, outreach will be conducted for prescribers of the antipsychotic in order to assess appropriateness of care, provide education on evidence-based use of non-pharmacological therapy, and facilitate access to services for appropriate patients.

The goal of this evaluation is to measure the impact on duration of therapy and metabolic monitoring under this policy.

Methods:
Members were identified for inclusion in the study based on paid or denied fee-for-service (FFS) claims for an antipsychotic medication. Antipsychotics were identified for inclusion based on their Preferred Drug List (PDL) class. The evaluation window for antipsychotic claims was from 10/1/2021 to 3/31/2022 for the control period before policy implementation and from 10/1/22 to 3/31/23 for the study period after policy implementation. The index event (IE) was the defined as the first paid or denied antipsychotic claim in the evaluation window. Denied claims were included based on error codes in **Appendix 1**.

For each patient, the baseline and follow-up periods were based on the IE.
- The baseline period was defined as the 90 days prior to the IE (exclusive of the IE).
- The follow-up period was defined as the 60 days following the IE (inclusive of the IE)

Inclusion Criteria:
1. Medicaid members with a paid or denied FFS claim for an antipsychotic in the evaluation window
2. Members less than or equal to 5 years of age at the time of the IE

Exclusion criteria:
1. Primary insurance coverage (i.e., third party liability [TPL]) at any time during the baseline or follow-up period
2. Non-continuous Medicaid eligibility during the baseline period
3. Non-continuous Medicaid eligibility during the follow-up period

4. Patients with Medicare Part D coverage or limited or no Medicaid drug benefit at any time during the baseline or follow-up periods. Claims data for these patients may be incomplete. Patients were identified based on the following benefit packages:

Category	Benefit Package	Description
Medicare Part D coverage	BMM	Qualified Medicare Beneficiary + Oregon Health Plan with Limited Drug
	BMD	Oregon Health Plan with Limited Drug
	MED	Qualified Medicare Beneficiary
Limited or no Medicaid drug benefit	MND	Transplant package
	CWM	Citizenship Waived Emergency Medical
	SMF	Special Low-Income Medicare Beneficiary Only
	SMB	Special Low-Income Medicare Beneficiary Only

Population descriptors included:

1. Members with a diagnosis of autism or self-harm in medical claims during the baseline or follow-up period or submitted with a PA
2. Coordinated Care Organization (CCO) enrollment at the time of the IE
3. Drug prescribed at the time of the IE
4. Current foster care enrollment (historical enrollment is unavailable)
5. Race and age

Outcomes that were planned for this analysis included:

1. Proportion of members with claims for metabolic monitoring (see **Appendix 1** for medical codes)
2. Proportion of members with prescriptions from a psychiatrist or developmental pediatrician (see **Appendix 1** for taxonomy codes)
3. Days covered by antipsychotic in the 6 months following the IE categorized as less than or equal to 30 days or more than 30 days

Chart notes submitted with PA requests were also reviewed.

Results:

The number of members included in this analysis are listed in **Table 1**. After exclusion of members with potentially incomplete claims data, there were 31 members in the 6 months before implementation of the PA and 41 members in the 6 months after implementation of the policy. Eight members were excluded from the post-implementation group because they were already included in the pre-implementation group. Baseline characteristics for these members are described in **Table 2**. Because of the small numbers of members, differences between groups are difficult to quantify. Members were primarily 4 or 5 years of age and enrolled in a CCO at the time of the first claim in the evaluation window. Most members identified as male (>70%) and white (>60%). Risperidone (58%) and aripiprazole (27%) accounted for the majority of claims. Five members had claims for olanzapine (15%). In 4 of these members, olanzapine was prescribed as an antiemetic for cancer.

Table 1. Included population of members with paid claims

Number of included patients	Before	After
Age ≤ 5 years with FFS paid or denied antipsychotic claim	32	51
After exclusion of Medicare, TPL, and limited drug eligibility groups	32	46
After exclusion of non-continuous Medicaid enrollment in the 60-day follow-up period	32	44
After exclusion of non-continuous Medicaid enrollment in 90-day baseline period	31	41
After exclusion of members in Post group who were already in the Pre group	**31**	**33**

Table 2. Baseline characteristics

	Before		**After**	
	31	%	33	%
Age				
2	1	3.2%	2	6.1%
3	4	12.9%	3	9.1%
4	7	22.6%	8	24.2%
5	19	61.3%	20	60.6%
Sex				
Female	7	22.6%	9	27.3%
Male	24	77.4%	24	72.7%
Race				
White	19	61.3%	20	60.6%
Unknown	9	29.0%	8	24.2%
American Indian/Alaskan Native	3	9.7%	2	6.1%
Other	0	0.0%	3	9.1%
Foster Care Enrollment (as of May 2023)	2	6.5%	5	15.2%
Managed Care Enrollment (as of IE)				
FFS		0.0%	2	6.1%
CCO	31	100.0%	31	93.9%
IE Drug				
risperidone	18	58.1%	19	57.6%
aripiprazole	7	22.6%	9	27.3%
olanzapine	3	9.7%	5	15.2%
quetiapine fumarate	3	9.7%	0	0.0%

After implementation of the policy, about half of members had an initial denied claim (n=17, 52%). The current policy allows members to fill 30 days without PA, and an initial denial for these members would indicate that they had claims for an antipsychotic in the prior year. Most members with an initial denied claim had subsequent paid claims.

This policy was implemented in conjunction with a retrospective provider educational initiative in which providers were faxed information about the new policy when a member had their first paid claim for an antipsychotic. The intent of this policy was to avoid interruptions in care by notifying providers of the PA requirement before members had a denied claim. Automated, retrospective faxes to providers notifying them about the policy were successfully transmitted for about 45% of members (n=15). Because of the low success rate with initial faxes, manual efforts were made to call provider offices and re-fax information about the policy.

The most common diagnoses present in medical claims were developmental disorders like autism spectrum disorder, ADHD, psychological development disorders, and language disorders (**Table 3**). Members frequently had more than one mental health diagnosis. Diagnoses related to self-harm, hostility, or violence were present for only one member in each group. There was no change in the number of members with prescriptions from a psychiatrist or neurodevelopmental pediatrician and only slight changes in the number of patients with claims for glucose monitoring or therapy beyond 30 days (**Table 4**).

Table 3. Most common mental health diagnoses (ICD-10 codes beginning with F) in medical claims or submitted with PAs

			Before					After	
			31	%				33	%
Top 10 Mental Health Diagnoses (ICD-10 beginning with F)									
1	F902	Attention-deficit hyperactivity disorder, combined type	13	41.9%	**1**	F840	Autistic disorder	14	42.4%
2	F88	Other disorders of psychological development	12	38.7%	**2**	F902	Attention-deficit hyperactivity disorder, combined type	14	42.4%
3	F840	Autistic disorder	9	29.0%	**3**	F88	Other disorders of psychological development	11	33.3%
4	F919	Conduct disorder, unspecified	8	25.8%	**4**	F802	Mixed receptive-expressive language disorder	9	27.3%
5	F802	Mixed receptive-expressive language disorder	8	25.8%	**5**	F419	Anxiety disorder, unspecified	8	24.2%
6	F3481	Disruptive mood dysregulation disorder	7	22.6%	**6**	F919	Conduct disorder, unspecified	7	21.2%
7	F909	Attention-deficit hyperactivity disorder, unspecified type	7	22.6%	**7**	F909	Attention-deficit hyperactivity disorder, unspecified type	6	18.2%
8	F8089	Other developmental disorders of speech and language	6	19.4%	**8**	F4389	Other reactions to severe stress	5	15.2%
9	F913	Oppositional defiant disorder	6	19.4%	**9**	F4310	Post-traumatic stress disorder, unspecified	5	15.2%
10	F419	Anxiety disorder, unspecified	6	19.4%	**10**	F3481	Disruptive mood dysregulation disorder	4	12.1%
10	F4310	Post-traumatic stress disorder, unspecified	6	19.4%	**10**	F411	Generalized anxiety disorder	4	12.1%
10	F918	Other conduct disorders	4	12.9%	**10**	F918	Other conduct disorders	4	12.1%
10	F809	Developmental disorder of speech and language, unspecified	4	12.9%					
10	F4325	Adjustment disorder w/mixed disturb of emotions and conduct	4	12.9%					

Table 4. Clinical Outcomes

	Before		After	
	31	%	33	%
Glucose monitoring in baseline or follow-up period	11	35.5%	13	39.4%
Psychiatrist or neurodevelopmental prescriber specialty	8	25.8%	8	24.2%
Days covered by antipsychotic in the following 6 months				
0 days		0.0%	4	12.1%
1-30 days	3	9.7%	5	15.2%
>30 days	28	90.3%	24	72.7%

Manual review of profiles

Of the 33 members in the study period after implementation of the safety edit, a PA was ultimately submitted for 24 members (73%; **Table 5**). For 51% of members, long-term antipsychotic therapy was approved. For 18% of members (n=6), a short-term approval was authorized for 3 months to avoid interruptions in therapy and allow the prescriber time to submit additional documentation required for longer approval. Subsequent glucose monitoring was conducted for 4 of these members, and one switched to alternate therapy after a denial for longer-term therapy. Eight members (24%) met criteria for a new start of an antipsychotic and had no subsequent PA requirement. Because the current PA criteria apply only to members who were less than or equal to 5 years of age, 7 members turned 6 years of age before a PA was required and one member had less than 30 days of therapy. A PA was initially denied for one member and no PA was submitted for another member. Manual review of submitted chart notes identified 14 members (42%) with explosive, combative, violent, or self-harmful behavior. Diagnoses documented in chart notes included cancer (n=4), autism (n=10), substance exposure as an infant or *in utero* (n=4), and other developmental disorders (n=8). Overall, diagnostic trends were consistent between medical claims and chart notes except for substance exposure and challenging behavior. These diagnoses were apparent in submitted chart notes but were not identified in medical claims.

Table 5. Manual Review of Outcomes of Prior Authorization Status

	Before		After	
Manual review of PA process	31		33	%
Auto-PA for first 30 days (no manual PA requirement)	1	3.2%	8	24.2%
PA Approved > 3 months	1	3.2%	17	51.5%
Short-term PA approval (3 months)	0	0.0%	6	18.2%
No PA submitted and subsequent denied claims	0	0.0%	1	3.0%
Denied PA only	1	3.2%	1	3.0%

Discussion and Limitations:

This analysis is significantly limited by the small numbers of members prescribed antipsychotics. As a claims-based analysis, this evaluation also has several inherent limitations including:

- Before and after study design which is unable to control for potential confounding factors.
- Diagnostic data may be incomplete or not accurately reflect true patient diagnoses. After comparison of diagnoses in medical claims and diagnoses submitted with PAs, we identified that challenging behavior (e.g., aggressive, combative, explosive, violent or self-harmful behavior) was rarely included in medical claims.
- Provider taxonomy, which was used to identify mental health providers, may not actually reflect the true provider specialty or area of practice.
- Use of days' supply on paid claims as a surrogate marker for duration of therapy. Days' supply may not reflect actual member adherence or medication use.
- Use of common codes for psychotherapy and laboratory tests which may not accurately reflect engagement for all types of non-pharmacologic therapies or glucose testing.
- Use of a short follow-up period may result in incomplete data on duration of therapy for some members. In order to maximize the number of people eligible for inclusion, a short follow-up duration (60 days) was chosen. However, based on profile review, members with approval for long-term therapy were inaccurately categorized using this duration. A post-hoc analysis was conducted to evaluate duration of therapy over 6 months instead of 60 days.

The small number of members made it difficult to identify patterns in utilization.

This policy was implemented and designed to avoid interruptions in care for members. Members were allowed to fill 30 days of an antipsychotic without a PA, and a retrospective educational fax was sent at the time of the first claim to notify providers of the PA requirement. If providers requested a PA but did not supply sufficient documentation for long-term approval, 90 days of therapy could be authorized in order to avoid interruptions in care while the provider submitted additional information. During implementation, there were manual efforts to call provider offices and notify providers of the PA requirement. However, despite this, many members still had denied claims for an antipsychotic. It is unclear why providers were unaware of the PA requirement. Potential reasons include:

1. Inaccurate contact information for providers resulting in inability to successfully send a fax notifying the provider of the PA requirement. It is unclear if faxes that were successfully transmitted to a fax number actually reached the provider.
2. Faxes were sent in advance of a denied claim and not at the time of the denial. For members who had intermittent antipsychotic use and had a significant time between their first and second antipsychotic claim, the fax was not temporally associated with the need for a PA request. Retrospective faxes to providers notifying them about the policy were successfully transmitted for about 45% of members (n=15) within the 90 days prior to a denied claim.
3. PA is required for each change in dose or change in drug. In most cases, providers start on a low dose and titrate the antipsychotic if needed to control symptoms. Even when providers submitted an initial PA, subsequent changes in dose or changes in therapy required submission of a new PA.
4. Many PA requests did not include sufficient information to approve long-term therapy. In many cases, a short-term PA was approved in order to give providers time to submit documentation of metabolic monitoring. If providers did not submit this information within 3 months, members may have had subsequent denied claims. Because short-term approval was authorized for most patients, a longer initial treatment duration may be reasonable.

There is insufficient information based on this analysis to determine if the safety edit for antipsychotics in children less than 6 years of age is improving rates of metabolic monitoring, the proportion of providers who consult with a psychiatrist, or the proportion of members who participate in psychotherapy. At the time of this analysis only 3 months of complete follow-up data were available for members in the study, and the small number of people identified for analysis make it difficult to compare differences between groups. However, there were several implementation trends that were apparent after a review of profiles.

- At the time a provider submits a PA, we are unable to distinguish between members in foster care and other Medicaid members. Members in foster care have the same PA requirements as all other Medicaid members (even if the Department of Human Services has already reviewed the medication). The retrospective program is able to incorporate foster care enrollment and can help coordinate care for these members.
- Prior authorizations are typically loaded for a specific drug and dose. Titration of medications or switching between medications because of intolerance or lack of benefit increases the administrative burden for providers.
- Prior authorization criteria were only applied for members younger than 6 years of age. Some members turned 6 years of age before the provider submitted information to support long-term antipsychotic use.
- The current policy uses a one-year lookback period to evaluate previous antipsychotic use. If no claims are identified, then 30 days is authorized to allow the prescriber time to submit information needed for ongoing therapy. However, if members use antipsychotics intermittently with a long period between the first and second claims, then the fax notifying the prescriber about the PA requirement was not temporally related to the member's second denied claim. Over 50% of members in this analysis (n=17) had an initial denied claim, despite efforts to notify prescribers about the PA requirement.
- Review of chart notes documented engagement in a wide variety of non-pharmacological therapies for members prescribed antipsychotics. Therapies included play therapy, occupational therapy, school-based therapies, developmental rehabilitation, attachment-based training, parent-child interaction therapy, and applied behavior analysis. Current criteria for use of antipsychotics do not require only referral for psychotherapy and do not require any particular type of non-pharmacologic therapy.

References:

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Appendix 1: Drug Coding

Table A1. Description of PICOs

Population	Medicaid members with a paid or denied FFS claim for antipsychotics in the evaluation window. AND age <=5 years at the time of the IE AND continuous Medicaid enrollment in the baseline (90 day) and follow-up (60 day) periods
Intervention	Continuation of antipsychotic beyond 30 days
Comparators	Members with antipsychotic claims from 10/1/2021 to 3/31/2022 vs. Members with antipsychotic claims from 10/1/2022 to 3/31/2023
Outcomes	Duration of antipsychotic use Glucose monitoring Specialist oversight Administrative burden of PA process – PAs, denied claims

Table A2. Specific Therapeutic Class for second generation antipsychotics

Specific Therapeutic Class	Generic
H7T	clozapine
H7T	risperidone
H7T	olanzapine
H7T	quetiapine fumarate
H7T	ziprasidone HCl
H7T	paliperidone
H7T	asenapine maleate
H7T	iloperidone
H7T	lurasidone HCl
H7T	asenapine
H7T	lumateperone tosylate
H7T	olanzapine/samidorphan malate
H7X	aripiprazole
H7X	brexpiprazole
H8W	cariprazine HCl
H8Y	pimavanserin tartrate

Table A3. Error codes for denied claims

Error Code	Error Status Description	Criteria for Study
513	RECIPIENT NAME AND NUMBER DISAGREE	Exclude
2002	RECIPIENT NOT ELIGIBLE FOR HEADER DATE OF SERVICE	Exclude
2809	DOB IS INVALID	Exclude
2508	RECIPIENT COVERED BY PRIVATE INSURANCE (PHARMACY)	Exclude
628	Other Coverage Reject Code Required for OCC 3	Exclude
503	DATE DISPENSED AFTER BILLING DATE	Exclude
643	INVALID OTHER COVERAGE CODE	Exclude
238	RECIPIENT NAME IS MISSING	Exclude
4999	THIS DRUG IS COVERED BY MEDICARE PART D	Exclude
3002	NDC REQUIRES PA	Include
4025	AGE IS NOT ALLOWED FOR NDC	Include
3000	UNITS EXCEED AUTHORIZED UNITS ON PA MASTER FILE	Include

Table A4. Psychiatrist prescriber taxonomies

Taxonomy	Taxonomy Description
2080P0006X	PHYSICIAN-PEDIATRICS-DEVELOPMENTAL BEHAVORIAL PEDIATRICS
2080P0008X	PHYSICIAN-PEDIATRICS-NEURODEVELOPMENTAL DISABILITIES
2084A0401X	PSYCHIATRY & NEUROLOGY, ADDICTION MEDICINE
2084B0002X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-BARIATRIC MEDICINE
2084B0040X	BEHAVIORAL NEUROLOGY & NEUROPSYCHIATRY
2084D0003X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-DIAGNOSTIC NEUROIMAGING
2084F0202X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-FORENSIC PSYCHIATRY
2084H0002X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-HOSPICE AND PALLIATIVE MEDICINE
2084N0008X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-NEUROMUSCULAR MEDICINE
2084N0400X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-NEUROLOGY
2084N0402X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-NEUROLOGY WITH SPECIAL QUAL IN CHILD NEUROLO
2084N0600X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-CLINICAL NEUROPHYSIOLOGY
2084P0005X	PHYSICIAN-PSYCHIATRY&NERUOLOGY-NEURODEVELOPMENTAL DISABILITIES
2084P0015X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-PSYCHOSOMATIC MEDICINE
2084P0800X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-PSYCHIATRY
2084P0802X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-ADDICTION PSYCHIATRY
2084P0804X	PHYSICIAN-PSYCHIATRY&NEUROLGY-CHILD&ADOLESCENT PSYCHIATRY
2084P0805X	PHYSICIAN-PSYCHIATRY&NEUROLGY-GERIATRIC PSYCHIATRY
2084P2900X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-PAIN MEDICINE
2084S0010X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-SPORTS MEDICINE
2084S0012X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-SLEEP MEDICINE
2084V0102X	PHYSICIAN-PSYCHIATRY&NEUROLOGY-VASCULAR NEUROLOGY

Table A5. Metabolic monitoring for glucose

CPT Code	Description
80048	Blood Test, Basic Group Of Blood Chemicals (Calcium, Total)
80049	Basic Metabolic Panel
80050	General Health Panel
80053	Blood Test, Comprehensive Group Of Blood Chemicals
80054	Comprehensive Metabolic Panel
80065	Metabolic Panel
81506	Endo Assay Seven Anal
82945	Glucose Other Fluid
82947	Assay Glucose Blood Quant
82948	Reagent Strip/Blood Glucose
82950	Glucose Test
82951	Glucose Tolerance Test (Gtt)
82952	Gtt-Added Samples
82953	Glucose-Tolbutamide Test
82954	Glucose, Urine
82961	Glucose Tolerance Test, Intravenous
82962	Glucose Blood Test
83036	Hemoglobin Glycosylated A1c
83037	Hb Glycosylated A1c Home Dev
95249	Cont Gluc Mntr Pt Prov Eqp
95250	Cont Gluc Mntr Phys/Qhp Eqp
95251	Cont Gluc Mntr Analysis I&R
0403T	Diabetes Prev Standard Curr
3044F	Hg A1c Level Lt 7.0%
3045F	Hg A1c Level 7.0-9.0%
3046F	Hemoglobin A1c Level >9.0%
3047F	Hemoglobin A1c Level = 9.0%
3051F	Hg A1c>Equal 7.0%<8.0%
3052F	Hg A1c>Equal 8.0%<Equal 9.0%
3754F	Screening Tests Dm Done
D0411	Hba1c In Office Testing
D0412	Blood Glucose Level Test
G0096	Basic Metabolic Panel (Carbon Dioxide (B

G0098	Comprehensive Metabolic Panel (Albumin-S
G2089	A1c Level 7 To 9%
G8015	Diabetic Pt W/ Hba1c>9%
G8016	Diabetic Pt W/ Hba1c<Or=9%
G8017	Dm Pt Inelig For Hba1c Measu
G8777	Diabetes Screen
TR200	Tracking Only - Hemoglobin A1c - <7.0
TR201	Tracking Only - Hemoglobin A1c - >7 <8.0
TR202	Tracking Only - Hemoglobin A1c - >8 <9.0
TR203	Tracking Only - Hemoglobin A1c - >9.0

Antipsychotics in Children

Goal(s):

- Ensure safe and appropriate use of antipsychotics in children
- Discourage off-label use not supported by compendia

Length of Authorization:

- Up to 12 months

Requires PA:

- Antipsychotic use beyond 60 days in children 3-6 years of age
- All antipsychotic use in children 2 years of age or younger

Note: olanzapine can be automatically approved in patients with a recent cancer diagnosis

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Table 1. FDA-Approved Indications and Ages for Oral Second-generation Antipsychotics in Children

FDA-Approved Indications and Ages				
Drug	**Schizophrenia**	**Bipolar I disorder**	**Major depressive disorder (adjunct)**	**Other**
aripiprazole	≥13 yrs	≥10 yrs	≥18 yrs	Irritability associated with Autistic Disorder ≥6 yrs Tourette's Disorder ≥6 yrs
asenapine maleate	≥18 yrs	≥10 yrs		
brexpiprazole	≥13 yrs			
lurasidone HCl	≥13 yrs	≥10 yrs		
olanzapine	≥13 yrs	≥13 yrs	≥18 yrs	
paliperidone	≥12 yrs			Schizoaffective disorder ≥18 yrs
quetiapine fumarate	≥13 yrs	≥10 yrs		Bipolar depression ≥18 yrs
risperidone	≥13 yrs	≥10 yrs		Irritability associated with Autistic Disorder ≥5 yrs

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is the request for use of olanzapine as an antiemetic associated with cancer or chemotherapy?	**Yes:** Approve for 12 months	**No:** Go to #3
3. Has the patient been screened for diabetes (blood glucose or A1C) within the last 12 months?	**Yes:** Go to #5	**No:** Go to #4
4. Is there documented clinical rationale for lack of metabolic monitoring (e.g. combative behaviors requiring sedation) OR documentation of patient weight before and after initiation of treatment? Note: Caregivers failing to take patients to the laboratory is not a clinical rationale for lack of monitoring.	**Yes:** Document rationale. Go to #5	**No:** Pass to RPh. Deny; medical appropriateness. Annual metabolic screening or consistent evaluation for rapid weight gain is required for chronic use of antipsychotics. Refer denied requests to the OHA for follow-up.
5. Is the patient engaged in, been referred for, or have documented inability to access evidence based first-line non-pharmacological therapy (e.g., applied behavior analysis therapy for autism, parent behavioral therapy, or parent child interaction therapy)?	**Yes:** Go to #6	**No:** Pass to RPh. Deny; medical appropriateness. Refer denied requests to the OHA for follow-up.
6. Is the drug prescribed by or in consultation with a child psychiatrist or developmental pediatrician?	**Yes:** Approve for up to 12 months or length of therapy, whichever is less	**No:** Go to #7

Approval Criteria		
7. Is there detailed documentation regarding risk/benefit assessment and the decision to prescribe antipsychotic therapy? A thorough assessment should include ALL the following: a. Multidisciplinary review including a mental health specialist b. Mental health assessment including documentation of diagnoses, symptoms, and disease severity c. Discussion and consideration of first-line non-pharmacological therapies d. Assessment of antipsychotic risks and monitoring strategies e. Specific therapeutic goals of antipsychotic therapy, and for ongoing therapy, discussion of progress toward or achievement of therapeutic goals (or reasons for lack of progress and remediation strategies) f. Anticipated duration of therapy g. Detailed follow-up plan	**Yes:** Approve for up to 12 months or length of therapy, whichever is less	**No:** Pass to RPh. Deny; medical appropriateness. Refer denied requests to the OHA for follow-up.

P&T/DUR Review: 2/24 (SS); 6/21(SS)
Implementation: 4/1/24; 10/1/22