

PA DEPARTMENT OF HUMAN SERVICES  
MAAC BRIEFING DOCUMENT  
ANTIPSYCHOTICS

**Proposed Effective Date:** January 5, 2026

**I. Requirements for Prior Authorization of Antipsychotics**

Proposed revisions are noted with a ~~strikethrough~~ for deletions and **bold and underline** for additions.

**A. Prescriptions That Require Prior Authorization**

Prescriptions for Antipsychotics that meet any of the following conditions must be prior authorized:

1. A non-preferred Antipsychotic. See the Preferred Drug List (PDL) for the list of preferred Antipsychotics at: <https://papdl.com/preferred-drug-list>.
2. An Antipsychotic with a prescribed quantity that exceeds the quantity limit. The list of drugs that are subject to quantity limits, with accompanying quantity limits, is available at: <https://www.pa.gov/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits>.
3. An Antipsychotic when prescribed for a child under 18 years of age.
4. An atypical Antipsychotic when there is a record of a recent paid claim for another atypical Antipsychotic in the point-of-sale online claims adjudication system (therapeutic duplication).
5. A typical Antipsychotic when there is a record of a recent paid claim for another typical Antipsychotic in the point-of-sale online claims adjudication system (therapeutic duplication).

**B. Revisions to Review of Documentation for Medical Necessity**

In evaluating a request for prior authorization of a prescription for an Antipsychotic, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Antipsychotic, **both of the following:**
  - a. **One** of the following:
    - i. Has a history of therapeutic failure of or a contraindication or an intolerance (such as, but not limited to, diabetes, obesity, etc.) to the preferred Antipsychotics approved or medically accepted for the beneficiary's diagnosis or indication
    - ii. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antipsychotic (does not apply to non-preferred brands when the

PA DEPARTMENT OF HUMAN SERVICES  
MAAC BRIEFING DOCUMENT  
ANTIPSYCHOTICS

therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred)

- b. **For Opipza (aripiprazole) film, has a contraindication or an intolerance to aripiprazole ODT that would not be expected to occur with Opipza (aripiprazole) film;**

**AND**

2. For an Antipsychotic for a child under the age of 18 years, **all** of the following:
- a. **Is age-appropriate according to U.S. Food and Drug Administration (FDA)-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,**
- b. Has severe symptoms related to psychotic or neuro-developmental disorders such as seen in, but not limited to, the following diagnoses:
- i. Autism spectrum disorder,
  - ii. Intellectual disability,
  - iii. Conduct disorder,
  - iv. Bipolar disorder,
  - v. Mood disorders with psychotic features,
  - vi. Tic disorder, including Tourette's syndrome,
  - vii. Transient encephalopathy,
  - viii. Schizophrenia and schizophrenia-related disorders,
- c. **One** of the following:
- i. If under 14 years of age, is prescribed the drug by or in consultation with **one** of the following:
    - a) Pediatric neurologist,
    - b) Child and adolescent psychiatrist,
    - c) Child development pediatrician
  - ii. If 14 years of age or older, is prescribed the drug by or in consultation with **one** of the following:
    - a) Pediatric neurologist,
    - b) Child and adolescent psychiatrist,
    - c) Child development pediatrician,
    - d) General psychiatrist,
- d. Has chart documented evidence of a comprehensive evaluation,

PA DEPARTMENT OF HUMAN SERVICES  
MAAC BRIEFING DOCUMENT  
ANTIPSYCHOTICS

- e. Has a documented plan of care that includes non-pharmacologic therapies (e.g., evidence-based behavioral, cognitive, and family based therapies) when indicated according to national treatment guidelines,
- f. **For an Antipsychotic with risk of metabolic changes,** has documented baseline monitoring of weight or body mass index (BMI), blood pressure, fasting glucose or hemoglobin A1c, fasting lipid panel, and extrapyramidal symptoms (EPS) using the Abnormal Involuntary Movement Scale (AIMS);

**AND**

- 3. For therapeutic duplication, **one** of the following:
  - a. For an atypical Antipsychotic, is being titrated to or tapered from another atypical Antipsychotic,
  - b. For a typical Antipsychotic, is being titrated to or tapered from another typical Antipsychotic,
  - c. Has a medical reason for concomitant use of the requested drugs that is supported by peer-reviewed medical literature or national treatment guidelines;

**AND**

- 4. If a prescription for an Antipsychotic is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR PREFERRED AND NON-PREFERRED ANTIPSYCHOTICS FOR CHILDREN UNDER 18 YEARS OF AGE: The determination of medical necessity of a request for renewal of a prior authorization for an Antipsychotic for a child under 18 years of age that was previously approved will take into account whether the beneficiary:

- 1. Has **all** of the following:
  - a. Documented improvement in target symptoms,
  - b. **For an Antipsychotic with risk of metabolic changes, both of the following:**
    - i. Documented monitoring of weight or BMI quarterly

PA DEPARTMENT OF HUMAN SERVICES  
MAAC BRIEFING DOCUMENT  
ANTIPSYCHOTICS

- ii. Documented monitoring of blood pressure, fasting glucose or hemoglobin A1c, fasting lipid panel, and EPS using AIMS after the first 3 months of therapy and then annually,
- c. Documented plan for taper/discontinuation of the Antipsychotic or rationale for continued use;

**AND**

- 2. For a non-preferred Antipsychotic with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested drug; **AND**
- 3. If a prescription for an Antipsychotic is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

**C. Clinical Review Process**

Except as noted below, prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antipsychotic. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer (a psychiatrist) for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer (a psychiatrist), the services are medically necessary to meet the medical needs of the beneficiary.

All requests for prior authorization of an antipsychotic drug for a child under 18 years of age will be automatically forwarded to a physician reviewer (a psychiatrist) for a medical necessity determination. The physician reviewer (a psychiatrist) will prior authorize the prescription based on **one** of the following:

- 1. The guidelines in Section B. 2. are met.
- 2. In the professional judgment of the physician reviewer (a psychiatrist), the services are medically necessary to meet the medical needs of the beneficiary.

**D. Dose and Duration of Therapy**

PA DEPARTMENT OF HUMAN SERVICES  
MAAC BRIEFING DOCUMENT  
ANTIPSYCHOTICS

Requests for prior authorization of an Antipsychotic for a child under 18 years of age will be approved as follows:

1. Initial requests for prior authorization of an Antipsychotic for a child under 18 years of age will be approved for up to three months.
2. Renewals of requests for prior authorization of an Antipsychotic for a child under 18 years of age will be approved for up to 12 months.