Clinical Policy: Psychotropic Medication Continuity of Care (COC)

Reference Number: GA.PMN.10
Effective Date: 12/16
Last Review Date: 10/2021 Revision Log
Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Psychotropic medication may need continued therapy in certain situations to maintain previously controlled behavior health

FDA Approved Indication(s)
Indicated for Food and Drug Administration (FDA) approved used of Antipsychotics, Antidepressants, and Central Nervous System (CNS) medications for Attention Deficit Hyperactivity Disorder (ADHD)

Policy/Criteria
It is the policy of health plans affiliated with Centene Corporation® that any FDA approved psychotropic medication class as listed is **medically necessary** for new members to the plan for continuity of care when the following criteria are met:

I. Initial Approval Criteria
*** Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria ***

A. Psychotropic Medication COC (must meet all)**:**
1. Prescribed by a Psychiatrist or psychiatric NP/PA for any FDA approved indication. or
2. Prescribed by a Physician, NP, or PA for a behavioral health diagnosis other than Severe Mental Illness such as: Schizophrenia, Schizoaffective, Bipolar Disorder, or any other related psychotic disorders.
3. Diagnosis of a current recognized DSM-V psychiatric disorder, **AND all of the following:**
   a) Member is new to the Plan (enrolled within last two months);
   b) Requested medication is for a current FDA approved indication for member age;
   c) Requested medication does not exceed FDA recommended maximum dosage or dosing frequency for member's age;
   d) Prescription records and/or chart notes clearly document members use of requested medication usage (Dose and Frequency);
   e) Chart notes or Prior Authorization Form document/demonstrate a positive response to use of requested medication therapy and duration of use;
   f) Member has been on therapy at least 3 months prior to request;

g) Prescription records/chart notes documenting adherence to therapy;
h) Generic version of drug will be dispensed if one is available.
i) Member is not currently on a medication of the same pharmacologic class

Approval duration: 6 months

II. Continued Therapy

A. Psychotropic Medication COC (must meet all)**:**

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member has shown a positive response to therapy

Approval duration: 12 months

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
ADHD: Attention Deficit Hyperactivity Disorder
CNS: Central Nervous System
DSM-V: Diagnostic and Statistical Manual of Mental Disorders, 5th Edition
FDA: Food and Drug Administration
MDD: Major Depressive Disorder

IV. : General Information

Medication management with psychotropics are mainstay along with psychotherapy for many psychiatric disease states. In some instances, medication management may be the only option. When it comes to schizophrenia, approximately 20-30 % of all patients do not respond adequately to an initial antipsychotic trial, where some studies show up to 60% of patients being treatment-resistant. In MDD, studies suggest that between 29 % and 46 % of depressed patients fail to respond fully to antidepressant treatment of adequate dose and duration. For many psychiatric health conditions there will be an increased risk of relapse with each subsequent episode. Therefore it is prudent to find a medication trial that improves the patient's symptoms and functionality for the well-being of the patient and/or their caregivers. Many psychotropics have various receptor binding profiles within their respective pharmacological class, making treatment response potentially very individualized. Also these medications may cause debilitating adverse effects additionally making treatment selection challenging. For the major psychiatric disease states there usually is an acute, maintenance/and or continuation phase of treatment response. Therefore it would be recommended to continue medication management with drugs that have shown improvement/stability for patients.

V. Dosage and Administration

Based on FDA approved use

VI. Product Availability

Varies on drugs

VII. References

1. Barbee J. Treatment-Resistant Depression. Psychiatric Times. 2009. http://www.psychiatrictimes.com/major-depressive-disorder/treatment-resistant-depression. Accessed 9/12/16
2. Shim S. Treatment-Resistant Schizophrenia. Psychiatric Times. 2009. http://www.psychiatrictimes.com/printpdf/treatment-resistant-schizophrenia/page/0/2. Accessed 9/12/16
3. Sinclair D. and Adams C. Treatment resistant schizophrenia: a comprehensive survey of randomised controlled trials. BMC Psychiatry 2014 14:253.
4. Dold M. Leucht S. Pharmacotherapy of treatment-resistant schizophrenia: a clinical perspective. Evid Based Mental Health May 2014 Vol 17 No 2 33

Reviews, Revisions, and Approvals	Date	Approval Date
Policy created.	12/2016	12/2016
Annual review. No changed made	9/2017	9/2017
Annual review. No changed made	3/2018	3/2018
Annual review. No changes made.	12/18	
Changed current Georgia policy templates to corporate standard templates for drug coverage criteria to meet corporate compliance. Changes/revisions included; new formatting, font size, use of standard policy language for each section of policy, and rearranged order of certain steps in criteria and sections.	2/21/19	2/2019
Annual review. Updated initial criteria for clarity on prescribing psychotropics based on diagnosis for non-psychiatric specialist by not allowing prescribing for diagnosis related to severe mental illness and other psychotic. Updated fonts for consistency.	1/2020	1/2020
Annual review. No changes made.	1/2021	1/2021
4Q 2021 annual review. No changes made.	10/2021	10/2021

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in

developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.