



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

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/>