P.O. Box 25010
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Antipsychotics in Children Under Age 10
Reference Number: ARTC.PHAR.500
Last Review Date: 06/24

Revision Log

Description
This policy is to determine coverage for requests for antipsychotics in children under the age of 10 years.

Policy
I. Initial Approval <10 years of age
1. Requested indication is consistent with FDA-labeling, approved compendia, and/or current clinical practice guidelines. Approvable indications include:
   a. Pediatric Bipolar Disorder
   b. Schizophrenia
   c. Behavioral Symptoms/irritability in Autism
   d. Tourette's Syndrome
   e. Behavioral Symptoms/Aggression in PDD
   f. Disruptive mood dysregulation disorder (DMDD)
   g. Psychosis
2. Medication meets Claim Edits for dose/quantity/cumulative quantity OR if requesting outside of the claim edits, the requested medication meets FDA-labeling, compendium support, or has been studied and found to be safe and effective for the exception to the claim edit being requested.
3. Signed informed consent required. If a member is a new start or has changed to a different chemical entity of antipsychotic agent than is found in their drug history, whether for a therapy change, or adding to existing therapy, the new drug entity will require a newly signed and dated informed consent form for the new agent. May use the Arkansas Medicaid form if provider does not have their own, but this specific form is not required. (https://ar.magellanrx.com/documents/268611/269351/Medication+Informed+Consent+Document+for+Behavioral+or+Psychiatric+Conditions+-+Clients+under+18+years+of+age.pdf/b36b6864-5a6e-a661-ae93-52ab33495ee1?t=1685118649854)
4. Metabolic labs must be monitored every 6 months, including both glucose and lipids. This must be submitted with each request. See reference below for examples of acceptable CPT codes.

Acceptable CPT codes for these criteria listed below (reminder, criteria require monitoring for both glucose (group-1) and lipids (group-2)):

***Group-1 (glucose codes)**: Criteria require one of the following that contain glucose monitoring in the previous 6 months from claim date of in-process claim:*
- *83036 (HbA1c), OR*
- *80050 (General Health Panel), OR*
- *80069 (Renal Function Panel), OR*
- *80047 (Basic Metabolic Panel), OR*

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- *80048 (Basic Metabolic Panel), OR*
- *80053 (Comprehensive metabolic panel), OR*
- *82962 (Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use) OR*
- *82948 (Glucose; blood, reagent strip) OR*
- *82947 (Glucose; quantitative, blood),*

***AND**, criteria require one of the following lipid panel tests or all of the individual lipid tests in previous 6 months from claim date of the in-process claim:*

Group-2 (lipid codes)

- *80061 (Lipid panel), OR*
- *83701 (High resolution fractionation and quantitation of lipoproteins), OR*
- *82465 (Cholesterol, serum or whole blood, total), AND 83718 (HDL cholesterol), AND 84478 (Triglycerides), AND 83721 (LDL Cholesterol)*

Approve at GPI 12. Approval duration: 12 months

II. Continued Therapy

1. Currently receiving medication via Centene benefit or Arkansas Medicaid benefit AND
2. Member has previously met initial approval criteria for diagnosis and clinical edits being requested AND
3. Member is responding positively to therapy AND
4. Provide copies of metabolic lab monitoring in past 6 months (glucose AND lipids). See metabolic labs monitoring guidelines in initial criteria above.

Approve at GPI 12. Approval duration: 12 months

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed	03/20	
Annual review. No changes.	07/21	
Annual review. No changes.	07/22	07/25/22
Annual review. Clarified that providers may use the state form, but that it's not required. Updated metabolic lab monitoring guidelines	07/23	07/24/23
Annual review. No changes.	06/24	07/30/24

References

1. Arkansas Medicaid Prescription Drug Program Prior Authorization Criteria, available at https://arkansas.magellanrx.com/provider/docs/rxinfo/PACriteria.pdf