Clinical Policy: Antipsychotic therapy and Metabolic Monitoring

Reference Number: IN.CP.PMN.502
Effective Date: 05/01/2021
Last Review Date: 05/01/2021
Line of Business: Medicaid

Revision Log

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

Description

The intent of the criteria is to promote prudent monitoring Antipsychotic therapies. See table 1 for list of targeted products

American Diabetes Association Guidelines:

The Consensus Statement from the American Diabetes Association, American Psychiatric Association and others recommend metabolic monitoring for patients taking antipsychotic medications to include blood glucose (fasting or HbA1C), fasting total lipid panel, waist circumference, and blood pressure at baseline, Abnormal values indicating obesity or overweight, pre-diabetes, diabetes, hypertension, or dyslipidemia should be treated appropriately or referred for treatment.

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of Managed Health Services (MHS) that Antipsychotic therapy is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. If one of the following CPT(See Table 2) codes are present in 18 month look back:

1. Hemoglobin A1C
2. Lipid Panel+
3. Approve for 12 months

B. Else if no CPT (See Table 2) codes are present in 18 month then approve for 6 months.

Approval duration: 12 months if testing found and 6 month is no testing found

II. Table 1: Targeted Products

Drug Name	GPI
ARIPIPRAZOLE (ABILIFY®)	592500150020**, 592500150072**, 592500150003**
ARIPIPRAZOLE INJECTION (ABILIFY MAINTENA®)	5925001500E4**, 5925001500G2**

ARIPIPRAZOLE LAUROXIL (ARISTADA®)	5925001520E4**
ASENAPINE (SAPHRIS®)	5915501510****
ASENAPINE TD PATCH (SECUADO®)	5915501500****
BREXPIPRAZOLE (REXULTI®)	592500200003**
CARIPRAZINE (VRAYLAR®)	5940001810****
ILOPERIDONE (FANAPT™)	5907003500****
CLOZAPINE (CLOZARIL®, FAZACLO®)	5915202000****
LUMATEPERONE (CAPLYTA®)	5940002240****
LURASIDONE HCL (LATUDA®)	5940002310****
OLANZAPINE + FLUOXETINE (SYMBYAX®)	6299500250****
OLANZAPINE (ZYPREXA®)	5915706000****
OLANZAPINE INJECTIONS (ZYPREXA RELPREVV®)	5915706010****
PALIPERIDONE (INVEGA®)	5907005000****
PALIPERIDONE INJECTABLE (INVEGA SUSTENNA®; INVEGA TRINZA®)	5907005010****
QUETIAPINE (SEROQUEL®)	5915307010****
RISPERIDONE (RISPERDAL®)	5907007000****
RISPERIDONE INJECTION (RISPERDAL CONSTA®)	5907007010****
RISPERIDONE SUBCUTANEOUS ER SUSP (PERSERIS®)	5907007000E4**
ZIPRASIDONE (GEODON®)	5940008510****
ZIPRASIDONE MESYLATE (GEODON® INJECTION)	5940008520****
CHLORPROMAZINE HCL	5920001510****
FLUPHENAZINE DECANOATE	5920002530****
FLUPHENAZINE HCL	5920002510****
HALOPERIDOL	5910001010****
HALOPERIDOL DECANOATE	5910001030****
HALOPERIDOL LACTATE	5910001020****
LOXAPINE SUCCINATE	5915402020****
MOLINDONE	59160050******
PERPHENAZINE	5920004500****
PIMOZIDE	6200003000****
THIORIDAZINE HCL	5920008010****
THIOTHIXENE	5930002010****
TRIFLUOPERAZINE HCL	5920008510****

III. Table 2: CPT Codes

Cholesterol Lab Test	82465
Cholesterol Lab Test	83718

Cholesterol Lab Test	83722
Cholesterol Lab Test	84478
Glucose Lab Test	80047
Glucose Lab Test	80048
Glucose Lab Test	80050
Glucose Lab Test	80053
Glucose Lab Test	80069
Glucose Lab Test	82947
Glucose Lab Test	82950
Glucose Lab Test	82951
Glucose with test strip	82962
Glucose with test strip	82948
HbA1c Lab Test	83036
HbA1c Lab Test	83037
LDL-C Lab Test	80061
LDL-C Lab Test	83700
LDL-C Lab Test	83701
LDL-C Lab Test	83704
LDL-C Lab Test	83721
HbA1c Test Result or Finding	3044F
HbA1c Test Result or Finding	3046F
HbA1c Test Result or Finding	3051F
HbA1c Test Result or Finding	3052F
Lipid panel	3011F
CKD panel with lipids	3278F
LDL-C Test Result or Finding	3048F
LDL-C Test Result or Finding	3049F
LDL-C Test Result or Finding	3050F

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy Created	03-8-21	
Annual Review. No Changes	10.22	

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.