

aripiprazole (Abilify)

Origination: 12/29/11	Revised: 05/07/12	Annual Review:
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Purpose:

To provide guidelines and criteria for the review and decision determination of requests for medications that requires prior authorization.

Background Information:

Medication Summary

- Aripiprazole is an atypical antipsychotic that is a partial agonist at the dopaminergic D₂ and the serotonergic 5-HT_{1A} receptors and an antagonist at the serotonergic 5-HT_{2A} receptor.
- Aripiprazole is FDA-approved for all of the following indications: bipolar disorder; schizophrenia; agitation with bipolar disorder or schizophrenia; irritability associated with autism; and as an adjunctive treatment for depression in adults only.

Reference Statement

- Guidelines are compiled from available US Food and Drug Administration (FDA) approved indications, general practice guidelines, and/or evidence-based uses established through phase III clinical studies without published conflicting data. Only clinical studies published in their entirety in reputable peer-reviewed journals will be evaluated.

Eligibility Criteria

- Member must be eligible and have applicable benefit coverage.
- Prior authorization requests that do not meet clinical criteria in this Procedure will be forwarded to a Clinical Pharmacist for review.

Exclusion Criteria

- Members with severe neutropenia (ANC<1000/mm³).
- Members with cardiac disease, especially heart failure, history of myocardial infarction or QT prolongation.
- Members less than 18 years old when treated for depression.

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Procedure:

- 1.0 Request for *initial therapy* with aripiprazole (Abilify) requires documentation from the Member's medical records maintained by the requesting independent practitioner's office verifying the following:
 - 1.1 Member is new Member to AvMed (eligibility within the past 120 days) and has been on targeted medication prior to joining AvMed (evidenced by progress notes from prescriber indicating use or documented previous fill history with pharmacy);
- OR**
- 1.1 Prescriber is a psychiatric specialist;
- 1.2 If all criteria are met, request may be approved for one (1) month with a quantity limit of 30 tablets for 30 days. Refills should continue to process every month thereafter.

References:

1. DRUGDEX[®] System (electronic version). Thomson MICROMEDEX, Greenwood Village, Colorado, USA. Available at: <http://csi.micromedex.com>.
2. Lexi-Comp Online (electronic version) Lexi-Comp Inc. 1978-2010, Hudson, Ohio, USA. Available at: <http://online.lexi.com/crlsql/servlet/crlonline>.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2011. URL: <http://www.clinicalpharmacology.com>. Accessed December 3, 2011.

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Disclaimer Information:

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed to determine coverage for AvMed Health Plans' benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. AvMed Health Plans makes coverage decisions using these guidelines, along with the Member's benefit document. The use of this guideline is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated.

Coverage Issues Guidelines and Medical Technology Assessment Recommendations are developed for selected therapeutic or diagnostic services found to be safe, but proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the AvMed Health Plans service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations.

Treating providers are solely responsible for the medical advice and treatment of Members. This guideline may be updated and therefore is subject to change.