Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	July 7, 2020

ANTIPSYCHOTIC POLYPHARMACY CRITERIA

LENGTH OF AUTHORIZATION: SIX MONTHS

REVIEW CRITERIA:
Approved Indications:

- **Schizophrenia spectrum disorders**
  - Must try at least **3** formulary antipsychotics (one must be clozapine).
  - Four to six weeks of maximum tolerated doses and failure due to:
    - Inadequate response, adverse reactions, and/or breakthrough symptoms
- **Bipolar Disorder, with psychosis and/or severe symptoms:**
  - Must try at least **4** evidence-based treatment options dependent upon episode type: manic or depressive
  - Four to six weeks of maximum tolerated doses and failure due to:
    - Inadequate response, adverse reactions, and/or breakthrough symptoms

CONTINUATION OF THERAPY:

- Patient met initial review requirements.
- Clinical response to therapy submitted (supporting documentation required).