Antipsychotics in Children Under Age 10

Reference Number: ARTC.PHAR.500
Last Review Date: 07/21 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 and metabolic labs are being monitored (https://arkansas.magellanrx.com/provider/docs/rxinfo/PsychotropicSafetyFlwsht.pdf)

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.

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

References

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