BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINES	**ORIGINAL EFFECTIVE DATE: 5/21/2020**
SECTION: DRUGS	**LAST REVIEW DATE: 5/19/2022**
	LAST CRITERIA REVISION DATE: 5/19/2022
	ARCHIVE DATE:

CAPLYTA® (lumateperone)

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. **All requested data must be provided.** Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

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Criteria:

- **Criteria for initial therapy:** Caplyta (lumateperone) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

  1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Psychiatrist

  2. Individual is 18 years of age or older

  3. A confirmed diagnosis of **ONE** of the following:
     a. Schizophrenia with a Positive and Negative Syndrome Scale (PANSS) total score of 70 indicating moderate to extreme symptoms
     b. Depressive episode associated with Bipolar I or Bipolar II as monotherapy or as adjunctive therapy with lithium or valproate

  4. **ONE** of the following:
     a. **For Schizophrenia**: Individual has failure, contraindication per FDA label or intolerance to **THREE** of the following:
        i. Aripiprazole (brand or generic)
        ii. Olanzapine (brand or generic)
        iii. Paliperidone (brand or generic)
        iv. Quetiapine (brand or generic)
        v. Quetiapine XR (brand or generic)
        vi. Risperidone (brand or generic)
        vii. Ziprasidone (brand or generic)

     b. **For Bipolar I or Bipolar II monotherapy**: Individual has failure, contraindication per FDA label or intolerance to **THREE** of the following:
        i. Quetiapine
        ii. Lurasidone
        iii. Valproate
        iv. Olanzapine plus fluoxetine
        v. Combination therapy with **EITHER**:
           1. Quetiapine (or lurasidone) plus lithium (or valproate)
           2. Lithium plus valproate (or lamotrigine)

  5. Individual does not have moderate to severe hepatic impairment (Child Pugh Class B and C)

  6. Individual does not have a recent history of myocardial infarction or unstable cardiovascular disease

  Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Caplyta (lumateperone) is considered ***medically necessary*** and will be approved when **ALL** of the following criteria are met:

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1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Psychiatrist

2. Individual's condition responded while on therapy
    a. Response is defined as:
        i. **For Schizophrenia:**
            1. Documented evidence of efficacy, disease stability and/or improvement demonstrated by an improvement in the Positive and Negative Syndrome Scale (PANSS) total score
            2. Less hallucinations, delusions, disorganized thoughts and behaviors, improved affect, improved socialization, improved energy, fewer to no hospitalizations over baseline

        ii. **For Bipolar I or Bipolar II depression:**
            1. At least a 50% improvement in the number, intensity, and frequency of symptoms

3. Individual has been adherent with the medication

4. Individual has not developed any significant adverse drug effects that may exclude continued use
    a. Significant adverse effect such as:
        i. Neuroleptic malignant syndrome
        ii. Significant blood dyscrasia or absolute neutrophil count (ANC) < 1,000/mm^3

5. There are no significant interacting drugs

6. Individual does not have moderate to severe hepatic impairment (Child Pugh Class B and C)

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

    1. **Off-Label Use of Non-Cancer Medications**

    2. **Off-Label Use of Cancer Medications**

Description:

Caplyta (lumateperone) is indicated for the treatment of schizophrenia in adults. It is not approved for the treatment of patients with dementia-related psychosis. It is also indicated for the treatment of depressive episodes associated with bipolar I or II disorder (bipolar depression) in adults, as monotherapy and as adjunctive therapy with lithium or valproate.

CAPLYTA® (lumateperone)

Caplyta (lumateperone) is a second-generation antipsychotic with antagonist activity at central serotonin 5-HT_{2A} receptors and postsynaptic antagonist activity at central dopamine D_2 receptors. Lumateperone has high binding affinity for serotonin 5-HT_{2A} receptors and moderate binding affinity for dopamine D_2 receptors. Lumateperone also has moderate binding affinity for dopamine D_1 and D_4 and adrenergic $alpha_{1A}$ and $alpha_{1B}$ receptors but has low binding affinity for muscarinic and histaminergic receptors.

Metabolic syndrome is characterized by elevated lipid profile, hypertension, hyperglycemia, and obesity (especially abdominal weight gain). Antipsychotic agents with greatest risk for metabolic syndrome are clozapine, olanzapine, and quetiapine. Aripiprazole, asenapine, lurasidone, and ziprasidone have the least risk.

Definitions:

Atypical (second generation) antipsychotics:

Generic agents*	Brand agents*
- aripiprazole (generic for Abilify) - clozapine (generic for Clozaril) - olanzapine (generic for Zyprexa) - palperidone ER (generic for Invega) - quetiapine (generic for Seroquel) - quetiapine XR (generic Seroquel XR) - risperidone (generic for Risperdal) - ziprasidone (generic for Geodon)	- aripiprazole lauroxil (Aristada) injection - asenapine (Saphris) - brexpiprazole (Rexulti) - cariprazine (Vraylar) - iloperidone (Fanapt) - lumateperone (Caplyta) - lurasidone (Latuda)

Informational purposes only, listing does not imply formulary status or whether or not precertification is required

Resources:

Caplyta (lumateperone) product information, revised by Intra-Cellular Therapies, Inc. 12-2021. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed May 05, 2022.

Kane J, Rubio JM, Kishimoto T, Correll CU. Evaluation and management of treatment-resistant schizophrenia. In: UpToDate, Marder S, Friedman M (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated March 09, 2021. Accessed May 05, 2022.

Siris SG, Braga RJ. Depression in schizophrenia. In: UpToDate, Marder S, Friedman M (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated December 28, 2020. Accessed May 05, 2022.

Shelton RC, Bobo WV. Bipolar major depression in adults: Choosing treatment. In: UpToDate, Keck P, Solomon D (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated August 10, 2021. Accessed May 05, 2022.

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Post RM. Bipolar mania in adults: Choosing maintenance treatment. In: UpToDate, Keck P, Solomon D (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated April 27, 2022. Accessed May 05, 2022.

Stovall J. Bipolar mania and hypomania in adults: Choosing pharmacotherapy. In: UpToDate, Keck P, Solomon D (Eds), UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Topic last updated April 27, 2022. Accessed May 05, 2022.