

Select Antipsychotic Drugs

Policy # 00707

Original Effective Date: 07/13/2020

Current Effective Date: 03/10/2025

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

When Services May Be Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Company may consider select antipsychotic drugs, including, but not limited to Secuado^{®†} (asenapine), Caplyta^{™†} (lumateperone), Lybalvi^{™†} (olanzapine and samidorphan), and Quetiapine 150 mg tablet to be **eligible for coverage**** when the below patient selection criteria are met.

Patient Selection Criteria

Coverage eligibility will be considered for select antipsychotic drugs, including, but not limited to Secuado (asenapine), Caplyta (lumateperone), Lybalvi (olanzapine and samidorphan), and Quetiapine 150 mg tablet when the following criteria are met for the requested drug:

- Requested drug is Secuado:
 - Patient has a diagnosis of schizophrenia; AND
 - Patient is 18 years of age or older; AND
 - Patient has tried and failed (e.g., intolerance or inadequate response) at least TWO formulary alternatives unless there is clinical evidence or patient history that suggests the use of formulary alternatives to treat schizophrenia will be ineffective or cause an adverse reaction to the patient. Examples of formulary alternatives include aripiprazole, Rexulti^{®†} (brexpiprazole), Vraylar^{®†} (cariprazine), paliperidone, olanzapine, quetiapine, risperidone, Fanapt^{®†} (iloperidone), Latuda^{®†} (lurasidone), clozapine, and ziprasidone.

*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
- Requested drug is Caplyta:
 - Patient is 18 years of age or older; AND
 - Patient has a diagnosis of ONE of the following:
 - Schizophrenia; OR
 - Depressive episodes associated with bipolar I or II disorder; AND

Select Antipsychotic Drugs

Policy # 00707

Original Effective Date: 07/13/2020

Current Effective Date: 03/10/2025

- Patient has tried and failed (e.g., intolerance or inadequate response) at least TWO formulary alternatives for the requested indication unless there is clinical evidence or patient history that suggests the use of the formulary alternatives will be ineffective or cause an adverse reaction to the patient. Formulary alternatives include aripiprazole, Rexulti (brexpiprazole), paliperidone, olanzapine, quetiapine, risperidone, Fanapt (iloperidone), Latuda (lurasidone), Vraylar (cariprazine), valproic acid, divalproex sodium, ziprasidone, and clozapine.
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
- Requested drug is Lybalvi:
 - Patient is 18 years of age or older; AND
 - Patient is not currently using opioids; AND
 - Patient meets ONE of the following:
 - Patient has a diagnosis of schizophrenia AND
 - ❖ Patient has tried and failed (e.g., intolerance or inadequate response) TWO alternative formulary drugs for the treatment of schizophrenia for at least 4 weeks EACH unless there is clinical evidence or patient history that suggest the use of the alternatives will be ineffective or cause an adverse reaction to the patient. Examples of alternative formulary drugs include aripiprazole, Rexulti (brexpiprazole), olanzapine, quetiapine, Fanapt (iloperidone), paliperidone, risperidone, Latuda (lurasidone), Vraylar (cariprazine), ziprasidone, and clozapine; OR
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*
 - Patient has a diagnosis of bipolar I disorder and meets BOTH of the following:
 - ❖ Patient has tried and failed (e.g., intolerance or inadequate response) lithium or valproic acid after at least 4 weeks unless there is clinical evidence or patient history that suggests the use of lithium or valproic acid will be ineffective or cause an adverse reaction to the patient; AND
*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*



Select Antipsychotic Drugs

Policy # 00707

Original Effective Date: 07/13/2020

Current Effective Date: 03/10/2025

- ❖ Patient has tried and failed (e.g., intolerance or inadequate response) at least one formulary antipsychotic drug for at least 4 weeks unless there is clinical evidence or patient history that suggests the formulary antipsychotic drugs will be ineffective or cause an adverse reaction to the patient. Examples of formulary antipsychotic drugs include aripiprazole, Rexulti (brexpiprazole), olanzapine, quetiapine, Fanapt (iloperidone), paliperidone, risperidone, Latuda (lurasidone), Vraylar (cariprazine), ziprasidone, and clozapine.

*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

- Requested drug is Quetiapine 150 mg tablet:
 - Patient has been receiving quetiapine using a different strength tablet; AND
 - Patient is unable to achieve the desired dose of quetiapine using the generically available quetiapine products.

*(Note: This specific patient selection criterion is an additional Company requirement for coverage eligibility and will be denied as not medically necessary** if not met.)*

When Services Are Considered Not Medically Necessary

Based on review of available data, the Company considers the use of Secuado (asenapine), Caplyta (lumateperone), and Lybalvi (olanzapine and samidorphan) for the treatment of schizophrenia when the patient has NOT tried and failed at least TWO formulary alternatives to be **not medically necessary.****

Based on review of available data, the Company considers the use of Caplyta for the treatment of bipolar depression when the patient has NOT tried and failed at least TWO formulary alternatives to be **not medically necessary.****

Based on review of available data, the Company considers the use of Lybalvi (olanzapine and samidorphan) for the treatment of bipolar I disorder when the patient has not tried and failed lithium or valproic acid to be **not medically necessary.****

Based on review of available data, the Company considers the use of Quetiapine 150 mg tablet when the patient is able to achieve the desired dose using a generic quetiapine product to be **not medically necessary.****



Select Antipsychotic Drugs

Policy # 00707

Original Effective Date: 07/13/2020

Current Effective Date: 03/10/2025

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of Secuado (asenapine), Caplyta (lumateperone), Lybalvi (olanzapine and samidorphan), and Quetiapine 150 mg tablet when the patient selection criteria are not met (except those denoted above as **not medically necessary****) to be **investigational**.*

Background/Overview

Schizophrenia is a psychiatric disorder involving chronic or recurrent psychosis. Symptoms are classified as either “positive” or “negative”. Positive symptoms include hallucinations or delusions, while negative symptoms include a flat affect. Of course, these symptoms are coupled with social and occupational impairments. The treatment of choice for schizophrenia is antipsychotic medications. Drug examples include aripiprazole, paliperidone, olanzapine, quetiapine, risperidone, and ziprasidone.

Bipolar disorder is a condition marked by episodes of mania, hypomania, and major depression. It can be classified into two subtypes: bipolar I disorder which consists of manic episodes and often hypomanic and depressive episodes, and bipolar II disorder which consists of hypomanic and depressive episodes without manic episodes. These recurrent mood episodes can be life threatening and warrant long-term maintenance pharmacotherapy. There are many options for treatment including lithium, valproate, quetiapine, lamotrigine, aripiprazole, olanzapine, and risperidone. Bipolar major depression is often treated with drugs such as quetiapine, Latuda (lurasidone), olanzapine, and the previously mentioned antimanic drugs.

This policy addresses three new drugs for the treatment of schizophrenia and bipolar disorder: Caplyta, Secuado, and Lybalvi. Caplyta is an oral atypical antipsychotic that demonstrated moderate efficacy in treating schizophrenia in two published, short-term trials (placebo-controlled). Only the 42 mg dose proved to be efficacious while lower and higher doses were not shown to be efficacious. Additional unpublished studies did not demonstrate efficacy of Caplyta. Two additional short-term (6-week) trials were conducted with Caplyta to demonstrate some efficacy in reducing symptoms of bipolar depression. The first investigated Caplyta as monotherapy and found an improvement of 4.6 points (out of a total of 60) on the Montgomery-Asburg Depression Rating Scale (MADRS) compared to placebo. The second investigated Caplyta in combination with lithium or valproate and found an improvement of 2.4 points on the MADRS in the Caplyta group compared to the placebo group. No studies exist that provide a direct comparison of Caplyta to other available antipsychotic products for the treatment of these conditions.



Select Antipsychotic Drugs

Policy # 00707

Original Effective Date: 07/13/2020

Current Effective Date: 03/10/2025

Secuado is a topical atypical antipsychotic which demonstrated modest efficacy in an unpublished trial in patients with schizophrenia. Its approval relied upon the efficacy data of a drug containing the same active ingredient, asenapine. There is a lack of head to head data versus other available antipsychotic agents. While the patch gives another alternative for therapy, it is associated with safety issues (including warnings regarding the application of external heat and application site reactions).

Lybalvi is a combination product containing olanzapine and the opioid receptor antagonist, samidorphan. The addition of samidorphan is designed to attenuate the weight-gain associated with olanzapine. The short-term (4-week) pivotal trial of this product demonstrated similar efficacy between Lybalvi and olanzapine in adults with schizophrenia; both agents were superior to placebo. This trial was not designed to evaluate differences in weight gain between the groups. An additional 24-week trial did evaluate the differences in weight gain and found significantly less weight gain with Lybalvi vs olanzapine in adults with schizophrenia. However, the olanzapine-subtracted difference in weight gain was -2.4%, which equates to an approximate 5-pound difference considering the average patient weight. It should be noted that patients in both groups gained weight overall, although the increases were smaller among patients randomized to Lybalvi. An additional limitation with this product is the warning regarding opioid use/withdrawal. Because it contains an opioid receptor antagonist, Lybalvi cannot be used in patients using opioids. It is also only available in limited fixed dose combinations which may not allow the patient to get the ideal dose of olanzapine for their condition. Given these limitations and the small potential benefit of Lybalvi, other antipsychotics may provide a more efficacious and economical option for patients.

This policy also addresses the branded Quetiapine 150 mg tablet. Because quetiapine is available generically in numerous formulations (including 25 mg, 50 mg, 100 mg, 200 mg, 300 mg, and 400 mg immediate release tablets and 150 mg, 200 mg, 300 mg, and 400 mg extended release tablets), this particular product likely does not provide any advantages over the existing products.

All medications targeted by this policy are considered alternatives for medications that already exist on the market today.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Both Caplyta and Secuado were approved in late 2019 for the treatment of schizophrenia in adult patients. In December 2021, the indication for Caplyta was expanded to include treatment of depressive episodes associated with bipolar I or II disorder in adults, as monotherapy and as adjunctive therapy with lithium or valproate.



Select Antipsychotic Drugs

Policy # 00707

Original Effective Date: 07/13/2020

Current Effective Date: 03/10/2025

Lybalvi was approved in May 2021 for the treatment of schizophrenia in adults, acute treatment of manic or mixed episodes and bipolar I disorder in adults as monotherapy and as adjunct to lithium or valproate, and maintenance treatment of bipolar I disorder in adults as monotherapy.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

This policy addresses new antipsychotic agents that do not bring any unique clinical advantages to the existing array of antipsychotic drugs that are available on the market. Given the lack of head to head data with these products compared to existing antipsychotic medications, Caplyta, Secuado, Lybalvi, and Quetiapine 150 mg tablets are considered alternatives to already existing antipsychotic medications on the market today.

References

1. Caplyta [package insert]. Intra-cellular Therapies, Inc. New York, New York. Updated December 2021.
2. Secuado [package insert]. Hisamitsu Pharmaceutical Company. Japan. Updated October 2019.
3. Caplyta Drug Evaluation. Express Scripts. Updated January 2020.
4. Secuado Drug Evaluation. Express Scripts. Updated December 2019.
5. Lybalvi [package insert]. Alkermes, Inc. Waltham, MA. Updated May 2021.
6. Lybalvi Drug Evaluation. Express Scripts. Updated July 2021.
7. Bipolar disorder in adults: Choosing maintenance treatment. UpToDate. January, 2022.
8. Bipolar major depression in adults: Choosing treatment. UpToDate. August, 2021.
9. Quetiapine Fumarate [package insert]. Rising Pharma Holdings, Inc. East Brunswick, NJ. Updated March 2022.

Policy History

Original Effective Date: 07/13/2020

Current Effective Date: 03/10/2025

06/04/2020 Medical Policy Committee review

06/10/2020 Medical Policy Implementation Committee approval. New policy.

06/03/2021 Medical Policy Committee review

06/09/2021 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.



Select Antipsychotic Drugs

Policy # 00707

Original Effective Date: 07/13/2020

Current Effective Date: 03/10/2025

02/03/2022 Medical Policy Committee review
02/09/2022 Medical Policy Implementation Committee approval. Added new drug, Lybalvi, to policy with relevant criteria and background information and updated criteria to reflect new indication for Caplyta. Also updated criteria for all drugs to include formulary brands as alternatives to try and fail prior to the requested drug.
02/02/2023 Medical Policy Committee review
02/08/2023 Medical Policy Implementation Committee approval. Added new Quetiapine 150 mg product with relevant criteria and background information.
02/01/2024 Medical Policy Committee review
02/14/2024 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
02/06/2025 Medical Policy Committee review
02/12/2025 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 02/2026

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

**Medically Necessary (or “Medical Necessity”) - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- A. In accordance with nationally accepted standards of medical practice;
- B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and



Select Antipsychotic Drugs

Policy # 00707

Original Effective Date: 07/13/2020

Current Effective Date: 03/10/2025

- C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, “nationally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient’s health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

