Division: Pharmacy Policy	Subject: Prior Authorization Criteria
Original Development Date: Original Effective Date: Revision Date:	July 1, 2022 August 11, 2022, October 11, 2022, January 24, 2024, March 18, 2025

ANTIPSYCHOTIC EXCEPTION CRITERIA

LENGTH OF AUTHORIZATION: Up to one year

REVIEW CRITERIA:

- Clinical documentation of medical necessity because:
  - The patient has a diagnosis of schizophrenia, schizotypal or delusional disorder and meets the following:
    - The drug product or medication of a similar drug class is prescribed for the treatment of schizophrenia or schizotypal or delusional disorders; **-AND-**
    - Prior authorization has been granted previously for the prescribed drug; **-AND-**
    - The medication was dispensed to the patient during the previous 12 months
- Medication requested must have the FDA approved indication and the patient must be within the FDA approved age limits.

Florida Medicaid Preferred Drug List:
https://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/fmpdl.shtml

DOSING AND ADMINISTRATION:

- Refer to product labeling at https://www.accessdata.fda.gov/scripts/cder/daf/