NC Division of Medical Assistance **Medicaid and Health Choice**
Outpatient Pharmacy **Effective Date:**
Prior Approval Criteria
Nuplazid

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Therapeutic Class Code: H8Y
Therapeutic Class Description: Antipsychotic-Atypical Selective Serotonin 5-HT2A Inverse Agonists (SSIA)

Medication	Generic Code Number(s)	NDC Number(s)
Nuplazid	41264	

Eligible Beneficiaries
NC Medicaid (Medicaid) beneficiaries shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) beneficiaries, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and must meet policy coverage criteria, unless otherwise specified. **EPSDT does not apply to NCHC beneficiaries**.

EPSDT Special Provision: Exception to Policy Limitations for Beneficiaries under 21 Years of

Age 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiaries under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate fora health problem, prevent it from worsening, or prevent the development of additional health problems.

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EPSDT and Prior Approval Requirements

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. Additional information on EPSDT guidelines may be accessed at http://www.ncdhhs.gov/dma/epsdt/.

Criteria for Initial Coverage:

All criteria A through E below shall be met.

A**.** A diagnosis of Hallucinations and/or delusions associated with Parkinson's Disease psychosis

AND
B**.** Be 18 years of age or older

AND
C. Prescriber has evaluated for other underlying conditions that may contribute to hallucinations and/or delusions.

AND
D**.** Prescriber has attempted to adjust Parkinson's Disease medications in order to reduce psychosis without worsening motor symptoms prior to requesting Nuplazid

AND
E**.** Nuplazid is being used with another Parkinson's disease medication

AND
F**.** Nuplazid is not being used to treat Alzheimer's dementia

AND
G. Beneficiary has been assessed for QTc prolongation (EKG)

Initial authorization shall be for 3 months

Criteria for Renewal Coverage:

A. Initial therapy met the criteria above
   AND

B. The Beneficiary has been assessed for improvement on Nuplazid

Renewal authorizations shall be for 6 months.

References

1. Prescriber Information—Nuplazid®. Acadia Pharmaceuticals, Inc., San Diego, CA. April 2017.

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Criteria Change Log

	Criteria effective date