Clinical Policy: Aripiprazole Orally Disintegrating Tablet

Reference Number: CP.PCH.37
Effective Date: 03.01.21
Last Review Date: 02.22
Line of Business: Commercial, HIM

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Aripiprazole orally disintegrating tablet (ODT) is an atypical antipsychotic.

FDA Approved Indication(s)

Aripiprazole ODT is indicated:

- For the treatment of schizophrenia
- For the acute treatment of manic and mixed episodes associated with bipolar I disorder
- For the adjunctive treatment of major depressive disorder
- For the treatment of irritability associated with autistic disorder
- For the treatment of Tourette's disorder

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that aripiprazole ODT is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. All FDA Approved Indications (must meet all)**:**

1. Diagnosis of one of the following (a, b, c, d, or e):
   a. Schizophrenia;
   b. Bipolar disorder;
   c. Major depressive disorder;
   d. Autistic disorder;
   e. Tourette's disorder;
2. Member meets one of the following (a, b, c, d, or e):
   a. Schizophrenia: Age ≥ 13 years;
   b. Bipolar disorder: Age ≥ 10 years;
   c. Major depressive disorder: Age ≥ 18 years;
   d. Autistic disorder: Age between 6 and 17 years;
   e. Tourette's disorder: Age between 6 and 18 years;
3. Member must use generic aripiprazole tablet and oral solution, unless clinically significant adverse effects are experienced or both are contraindicated;
4. For major depressive disorder, aripiprazole ODT is prescribed concurrently with an antidepressant;
5. Dose does not exceed any of the following (a, b, or c):

a. Schizophrenia, bipolar disorder: 30 mg (2 tablets) per day;
b. Major depressive disorder, autistic disorder: 15 mg (1 tablet) per day;
c. Tourette's syndrome (i or ii):
   i. Weight < 50 kg: 10 mg (1 tablet) per day;
   ii. Weight ≥ 50 kg: 20 mg (2 tablets) per day.

Approval duration:
HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and HIM.PA.154 for health insurance marketplace.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Documentation supports that member is currently receiving aripiprazole ODT for bipolar disorder or schizophrenia and has received this medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed any of the following (a, b, or c):
   a. Schizophrenia, bipolar disorder: 30 mg (2 tablets) per day;
   b. Major depressive disorder, autistic disorder: 15 mg (1 tablet) per day;
   c. Tourette's syndrome (i or ii):
      i. Weight < 50 kg: 10 mg (1 tablet) per day;
      ii. Weight ≥ 50 kg: 20 mg (2 tablets) per day.

Approval duration:
HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

B. Other diagnoses/indications (must meet 1 or 2)**:**

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and HIM.PA.154 for health insurance marketplace.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and HIM.PA.154 for health insurance marketplace, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
ODT: orally disintegrating tablet

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
aripiprazole (Abilify®) tablet or oral solution	**Bipolar Disorder and Schizophrenia** Adults: 10 to 15 mg PO QD **Major Depressive Disorder, Autistic Disorder, and Tourette's Disorder** 5 to 10 mg PO QD	Bipolar Disorder and Schizophrenia: 30 mg/day Major Depressive Disorder, Autistic Disorder: 15 mg/day Tourette's Disorder: 20 mg/day

Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.
**Off-label*

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): known hypersensitivity to aripiprazole
- Boxed warning(s): elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Aripiprazole is not approved for the treatment of patients with dementia-related psychosis.

V. Dosage and Administration

Indication	Dosing Regimen**	Maximum Dose
Schizophrenia	Adults: 10 to 15 mg PO QD Adolescents: initial: 2 mg PO QD; target: 10 mg PO QD	30 mg/day
Bipolar mania	Adults, as monotherapy: 15 mg PO QD Adults, as adjunct to lithium or valproate: 10 to 15 mg PO QD	30 mg/day

Indication	Dosing Regimen**	Maximum Dose
	Pediatric, as monotherapy or as an adjunct to lithium or valproate: initial: 2 mg PO QD; target: 10 mg PO QD	
Major depressive disorder	Adults, as adjunct to antidepressants: initial: 2 to 5 mg PO QD; target: 5 to 10 mg PO QD	15 mg/day
Irritability associated with autistic disorder	Pediatric: initial: 2 mg PO QD; target: 5 to 10 mg PO QD	15 mg/day
Tourette's disorder	Weight < 50 kg: initial: 2 mg PO QD; target: 5 mg PO QD Weight ≥ 50 kg: initial: 2 mg PO QD; target: 10 mg PO QD	Weight < 50 kg: 10 mg/day Weight ≥ 50 kg: 20 mg/day

***Known CYP2D6 poor metabolizers: half of the usual dose*

VI. Product Availability

Orally disintegrating tablets: 10 mg, 15 mg

VII. References

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4. Gelenberg AJ, et al. Practice guideline for the treatment of patients with major depressive disorder, third edition. Arlington, VA: American Psychiatric Association; May 2010. Available online at https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines. Accessed November 30, 2019.
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6. Dixon L, Perkins D, Calmes C. Guideline watch: practice guideline for the treatment of patients with schizophrenia. Arlington, VA: American Psychiatric Association; September 2009. Available online at http://www.psychiatryonline.org/guidelines. Accessed November 30, 2019.

7. Murphy TK, Lewin AB, Storch EA, Stock S, and the American Academy of Child and Adolescent Psychiatry (AACAP) Committee on Quality Issues (CQI). Practice parameter for the assessment and treatment of children and adolescents with tic disorders. J Am Acad Child Adolesc Psychiatry. 2013; 52(12): 1341-1359.
8. Volkmar F, Siegel M, Woodbury-Smith M, et al. Practice parameter for the assessment and treatment of children and adolescents with autism spectrum disorder. J Am Acad Child Adolesc Psychiatry 2014; 53: 237.
9. Keepers G, Fochtmann L, Anzia J, et al. APA Practice guideline for the treatment of patients with schizophrenia, third edition. Am J Psychiatry. 2020 Sept;177(9):868-872.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created: adapted from previously approved policy CP.CPA.179; retire CP.CPA.179; added HIM line of business; no significant changes from previously approved policy; 1Q 2021 annual review: no significant changes; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	11.29.20	02.21
1Q 2022 annual review: no significant changes; converted "Medical justification" to "Member must use" language; revised Commercial approval duration from Length of Benefit to 12 months or duration of request, whichever is less; references reviewed and updated.	11.13.21	02.22

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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