Clinical Policy: Lurasidone (Latuda)
Reference Number: CP.PMN.50
Effective Date: 08/15
Last Review Date: 05/17
Line of Business: Medicaid

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

Description
Lurasidone (Latuda®) is an atypical antipsychotic.

FDA approved indication
Latuda is indicated:
- For the treatment of schizophrenia in adults and adolescents (13 to 17 years)
- For the treatment of depressive episodes associated with bipolar disorder (bipolar depression), as monotherapy and as adjunctive therapy with lithium or valproate

Policy/Criteria
Provider must submit documentation (including office chart notes and lab results) supporting that member has met all approval criteria

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

I. Initial Approval Criteria

A. Bipolar Disorder or Schizophrenia (must meet all):
   - Diagnosis of bipolar disorder or schizophrenia;
     1. Member meets one of the following (a or b):
        1. Age ≥ 18 years;
        2. Failure of a ≥ 4 week trial of each of two PDL generic atypical antipsychotics at up to maximally tolerated indicated doses, each trialed for ≥ 4 weeks of two PDL generic atypical antipsychotics each for ≥ 4 weeks, unless member experiences clinically significant adverse effects or has contraindication(s); contraindicated or clinically significant adverse effects are experienced;
     2. OR
        - Contraindication to ALL PDL generic antipsychotics FDA approved for member’s diagnosis;
   3. Dose does not exceed 160 mg per day (2 tablets/day).
   Approval duration: 12 months

B. Other diagnoses/indications
   1. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy
A. All Indications (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Latuda for bipolar disorder or schizophrenia and has received this medication for at least 30 days;
2. Documentation of positive response to therapy;
3. If request is for a dose increase, new dose does not exceed 160 mg per day (2 tablets/day).

Approval duration: 12 months

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

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy; or
2. Refer to CP.PMN.53 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

Approval duration: 12 months

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 policy – CP.PMN.53 or evidence of coverage documents;
B. [Indications/diagnoses/situations in which drug is unsafe/ineffective]

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
PDL: preferred drug list

V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>Adults: 40 mg to 160 mg per day</td>
<td>160 mg/day</td>
</tr>
<tr>
<td></td>
<td>Adolescents: 40 mg to 80 mg per day</td>
<td>80 mg/day</td>
</tr>
<tr>
<td>Bipolar depression (bipolar disorder)</td>
<td>20 mg to 120 mg per day</td>
<td>160 mg/day</td>
</tr>
</tbody>
</table>

VI. Product Availability

Tablets: 20 mg, 40 mg, 60 mg, 80 mg, and 120 mg

VII. Workflow Document

Latuda WF.docx

VIII. References


Reviews, Revisions, and Approvals

| New guideline created – replaces CP.PMN.56 | 08/15 | 08/15 |
| Updated references and added general statement that the dose does not exceed the plan daily quantity limit. | 04/16 | 05/16 |
| No clinical changes to criteria | 03/17 | 05/17 |
| Converted to new template | |
| Removed age criteria as age is not an absolute contraindication per FDA labeling | |
| Updated references | |

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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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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