Clinical Policy: Olanzapine Long-Acting Injection (Zyprexa Relprevv)

Reference Number: AZ.CP.PHAR.292
Effective Date: 08.20
Last Review Date: 07.20
Line of Business: Arizona Medicaid

Revision Log

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

Description
Olanzapine (Zyprexa Relprevv®) is a long-acting atypical antipsychotic.

AHCCCS preferred drugs in this class include: Aristada Initio, Aristada, Abilify Maintena, Invega Sustenna, Invega Trinza, Risperdal Consta.

AHCCCS non-preferred drugs in this class include Zyprexa Relprevv

FDA approved indications
Zyprexa Relprevv is indicated for the treatment of schizophrenia.

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 Arizona Complete Health that Zyprexa Relprevv is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Schizophrenia (must meet all)**:**

1. Diagnosis of schizophrenia;
2. Prescribed by or in consultation with a psychiatrist;
3. Age ≥ 18 years;
4. Member meets one of the following (a or b):
   a. History of non-adherence to oral antipsychotic therapy (*see Appendix D for examples*) and has established tolerability to oral olanzapine;
   b. Therapy was initiated in an inpatient setting during a recent (within 60 days) hospital admission;
5. Failure of two AHCCCS Preferred Long Acting Injectable Antipsychotics at up to maximally indicated doses, each used for 4 weeks, unless contraindicated or clinically significant adverse effects are experienced;
6. Dose does not exceed 405 mg every 4 weeks or 300 mg every 2 weeks.

Approval duration: 6 months

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): AZ.CP.PMN.53 for Arizona Medicaid.

II. Continued Therapy

A. Schizophrenia (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports one of the following (a or b):
   a. Member is currently receiving Zyprexa Relprevv for schizophrenia and has received this medication for at least 30 days;
   b. Therapy was initiated in an inpatient setting for schizophrenia during a recent (within 60 days) hospital admission;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 405 mg every 4 weeks or 300 mg every 2 weeks.

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.
   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): AZ.CP.PMN.53 for Arizona Medicaid.

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 – AZ.CP.PMN.53 for Arizona Medicaid.
B. Dementia-related psychosis;
C. Alzheimer's disease.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration

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
olanzapine (Zyprexa®)	Schizophrenia 5 to 10 mg PO QD	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.

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): Patients are at risk for severe sedation (including coma) or delirium after each injection and must be observed for at least 3 hours in a registered facility with ready access to emergency response services.

Appendix D: Examples of Oral Antipsychotics – Generic (Brand)

Typical/First Generation Antipsychotics†	Atypical/Second Generation Antipsychotics
Chlorpromazine (Thorazine®) Fluphenazine (Prolixin®) Haloperidol (Haldol®) Loxapine (Loxitane®) Perphenazine (Trilafon®) Pimozide (Orap®) Thioridazine (Mellaril®) Thiothixene (Navane®) Trifluoperazine (Stelazine®)	Aripiprazole (Abilify®)* Asenapine maleate (Saphris®) Brexpiprazole (Rexulti®) Cariprazine (Vraylar®) Clozapine (Clozaril®) Iloperidone (Fanapt®) Lumateperone (Caplyta®) Lurasidone (Latuda®) Olanzapine (Zyprexa®)* Olanzapine/Fluoxetine (Symbyax®) Paliperidone (Invega®)* Quetiapine (Seroquel®) Risperidone (Risperdal®)* Ziprasidone (Geodon®)

Appendix E: General Information

Zyprexa Relprevv is available only through a restricted distribution program called Zyprexa Relprevv Patient Care Program and requires prescriber, healthcare facility, patient, and pharmacy enrollment. Adverse events with signs and symptoms consistent with olanzapine overdose, in particular, sedation (including coma) and/or delirium, have been reported following injections of Zyprexa Relprevv. The goal of the Zyprexa Relprevv Patient Care Program is to mitigate the risk of negative outcomes associated with Zyprexa Relprevv post-injection delirium/sedation syndrome.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Schizophrenia	IM: 150 mg/2 weeks, 300 mg/4 weeks, 210 mg/2 weeks, 405 mg/4 weeks, or 300 mg/2 weeks Zyprexa Relprevv should be administered by a healthcare professional.	405 mg every 4 weeks or 300 mg every 2 weeks

VI. Product Availability

Powder for suspension: 210 mg, 300 mg, and 405 mg

VII. References

1. Zyprexa Relprevv Prescribing Information. Indianapolis, IN: Lilly USA, LLC; October 2019. Available at https://www.zyprexarelprevvprogram.com/public/Default.aspx. Accessed May 4, 2020.
2. Kim B, Lee SH, Yang YK, et al. Review Article: Long-acting injectable antipsychotics for first-episode schizophrenia: The pros and cons. Schizophr Res Treatment. August 14, 2012; 2012: 560836. doi:10.1155/2012/560836
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2020. Available at: http://www.clinicalpharmacology-ip.com/. Accessed May 4, 2020.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	07.09.20	07.20

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.