

Clinical Policy: Cariprazine (Vraylar)

Reference Number: AZ.CP.PMN.91

Effective Date: 08.08.17

Last Review Date: 01.20

Line of Business: Arizona Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Cariprazine (Vraylar[®]) is an atypical antipsychotics.

FDA approved indication(s)

Vraylar is indicated for:

- Treatment of schizophrenia in adults
- Acute treatment of manic or mixed episodes associated with bipolar I disorder in adults
- Treatment of depressive episodes associated with bipolar I disorder (bipolar depression) in adults

Policy/Criteria

Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of Arizona Complete Health that Vraylar is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Bipolar Disorder and Schizophrenia (must meet all):

1. Diagnosis of bipolar disorder or schizophrenia spectrum disorder (schizophrenia, schizoaffective disorder, schizophreniform disorders)
2. Age \geq 18 years;
3. Member meets one of the following (a or b):
 - a. For treatment of depressive episodes of Bipolar I disorder: Failure of quetiapine, Latuda (lurasidone), and olanzapine, at up to maximally indicated doses, each trialed for \geq 4 weeks, unless contraindicated or clinically significant adverse effects are experienced;
 - b. For treatment of Schizophrenia spectrum disorder or manic or mixed episodes of Bipolar I disorder: Failure of 3 preferred atypical antipsychotics, one of which must be aripiprazole, at up to maximally indicated doses, each trialed for \geq 4 weeks, unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed any of the following:
 - a. Schizophrenia or manic or mixed episodes of bipolar I disorder: 6 mg (1 capsule) per day;
 - b. Depressive episodes of bipolar I disorder: 3 mg (1 capsule) per day.

Approval duration: 12 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. All Requests from Section I (must meet all):

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Vraylar for bipolar or schizophrenia spectrum disorder 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. Schizophrenia or manic or mixed episodes of bipolar I disorder: 6 mg (1 capsule) per day;
 - b. Depressive episodes of bipolar I disorder: 3 mg (1 capsule) per 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.

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 policy- AZ.CP.PMN.53 for Arizona Medicaid or evidence of coverage documents.

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
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aripiprazole (Abilify [®])	Bipolar Disorder and Schizophrenia Adults: 10-30 mg by mouth daily	30 mg/day
Clozapine	<ul style="list-style-type: none"> • Schizophrenia 12.5 mg-450 mg in divided doses 	900 mg/day
ziprasidone (Geodon [®])	Schizophrenia 20 mg PO BID Bipolar Disorder Initial: 40 mg PO BID; target: 40 to 80 mg PO BID	160 mg/day
Latuda [®] (lurasidone)	Schizophrenia 40 mg – 160 mg PO QD with food. Depression associated with bipolar I disorder (bipolar depression) 20 mg – 120 mg PO QD with food	160 mg/day
risperidone (Risperdal [®])	Schizophrenia Initial: 1 mg PO BID or 2 mg PO QD; target: 4 to 8 mg PO QD Bipolar Disorder 2 to 3 mg PO QD	16 mg/day
quetiapine (Seroquel [®])	Schizophrenia Initial: 25 mg PO BID; target: 400 to 800 mg/day Bipolar Disorder Initial: 50 mg PO BID; target: 400 to 800 mg/day Bipolar depression during depressive episodes of bipolar I or bipolar II disorder 300 mg PO QD at bedtime	800 mg/day
olanzapine (Zyprexa [®])	Schizophrenia Initial: 5 to 10 mg PO QD; target: 10 mg PO QD Bipolar Disorder Monotherapy: 10 to 15 mg PO QD; adjunct to lithium or valproate: 10 mg PO QD Depressive episodes associated with Bipolar I disorder (bipolar depression) in combination with fluoxetine olanzapine 5 mg PO and fluoxetine 20 mg PO once daily in the evening	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): known hypersensitivity to Vraylar
- Boxed warning(s): Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Vraylar is not approved for the treatment of patients with dementia-related psychosis.

Appendix D: General Information

- Schizophrenia Spectrum and other psychotic disorders include schizophrenia, and other psychotic disorders and schizotypal (personality) disorder. They are defined by abnormalities in one or more of the following 5 domains: Delusions, hallucinations, disorganized thinking, grossly disorganized or abnormal motor behavior including catatonia, and negative symptoms.
- Vraylar and aripiprazole are both dopamine partial agonists.

Clinically Important Drug Interactions with Vraylar

Strong CYP3A4 Inhibitors	
Clinical Impact:	Concomitant use of VRAYLAR with a strong CYP3A4 inhibitor increases the exposures of cariprazine and its major active metabolite, didesmethylcariprazine (DDCAR), compared to use of VRAYLAR alone
Intervention:	If VRAYLAR is used with a strong CYP3A4 inhibitor, reduce VRAYLAR dosage
Examples:	itraconazole, ketoconazole

- Pregnancy Risk Summary- Neonates exposed to antipsychotic drugs during the third trimester of pregnancy are at risk for extrapyramidal and/or withdrawal symptoms following delivery.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Schizophrenia	1.5 mg to 6 mg once per day	6 mg per day
Bipolar Mania	Manic or mixed episodes: 3 mg to 6 mg PO QD Depressive episodes: 1.5 mg or 3 mg PO QD	Manic or mixed episodes: 6 mg/day Depressive episodes: 3 mg/day

VI. Product Availability

Capsules: 1.5 mg, 3 mg, 4.5 mg, and 6 mg

VII. References

1. Vraylar Prescribing Information. Irvine, CA: Allergan USA, Inc.; May 2019. Available at: <http://www.vraylar.com/>. November 30, 2019.
2. Lehman AF, Lieberman JA, Dixon LB et al. Practice guideline for the treatment of patients with schizophrenia, second edition. Am J Psychiatry. 2004 Feb;161(2 Suppl):1-56.

3. American Psychiatric Association. Practice guideline for the treatment of patients with bipolar disorder. Am J Psychiatry. 2002 Apr;159(4 Suppl):1-50.
4. American Psychiatric Association Practice Guideline for the Treatment of Patients with Bipolar Disorder: Second Edition (2010). Available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf. Accessed November 30, 2019.
5. Crismon ML, Argo TR, Bendele SD, et al. Texas Medication Algorithm Project Procedural Manual: Bipolar Disorder Algorithms. July 2007. Available at: https://www.jpshhealthnet.org/sites/default/files/tmap_bipolar_2007.pdf. Accessed November 30 2019.
6. Micromedex[®] Healthcare Series [Internet database]. Greenwood Village, Colo: Thomson Healthcare. Updated periodically. Accessed November 30, 2019.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Converted to new template. Updated references	05/2018	07/18
Renumbered the policy. Added new indication of Bipolar Depression. Updated Appendix B dosing. Removed Saphris. Updated references.	09/2019	09/2019
Renumbered from AZ.CP.PMN.92 to AZ.CP.PMN.91 to align with Corporate criteria. Updated references.	01/2020	01/2020

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.

CLINICAL POLICY

Cariprazine



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.

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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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