Clinical Policy: Olanzapine Long-Acting Injection (Zyprexa Relprevv)
Reference Number: CP.PHAR.292
Effective Date: 12.01.16
Last Review Date: 08.18
Line of Business: Medicaid

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.

FDA Approved Indication(s)
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 health plans affiliated with Centene Corporation® 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. History of non-adherence to oral antipsychotic therapy (see Appendix D for examples);
      5. Established tolerability with oral olanzapine;
      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): CP.PMN.53 for Medicaid.

II. Continued Therapy
   A. Schizophrenia (must meet all):
      1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Zyproxa Relprevv for 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 405 mg every 4 weeks or 300 mg every 2 weeks.
CLINICAL POLICY
Olanzapine Long-Acting Injection

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 6 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.PMN.53 for 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 – CP.PMN.53 for Medicaid or evidence of coverage documents;
   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.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>olanzapine</td>
<td>Schizophrenia</td>
<td>20 mg/day</td>
</tr>
<tr>
<td>(Zyprexa®)</td>
<td>5 to 10 mg PO QD</td>
<td></td>
</tr>
</tbody>
</table>

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
Not applicable

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

<table>
<thead>
<tr>
<th>Typical/First Generation Antipsychotics†</th>
<th>Atypical/Second Generation Antipsychotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine (Thorazine®)</td>
<td>Aripiprazole (Abilify®)*</td>
</tr>
<tr>
<td>Fluphenazine (Prolixin®)</td>
<td>Asenapine maleate (Saphris®)</td>
</tr>
<tr>
<td>Haloperidol (Haldol®)</td>
<td>Brexpiprazole (Rexulti®)</td>
</tr>
<tr>
<td>Loxapine (Loxitane®)</td>
<td>Cariprazine (Vraylar®)</td>
</tr>
<tr>
<td>Perphenazine (Trilafon®)</td>
<td>Clozapine (Clozaril®)</td>
</tr>
<tr>
<td>Pimozide (Orap®)</td>
<td>Iloperidone (Fanapt®)</td>
</tr>
<tr>
<td>Thioridazine (Mellaril®)</td>
<td>Lurasidone (Latuda®)</td>
</tr>
<tr>
<td>Thiothixene (Navane®)</td>
<td>Olanzapine (Zyprexa®)*</td>
</tr>
</tbody>
</table>
**CLINICAL POLICY**

**Olanzapine Long-Acting Injection**

<table>
<thead>
<tr>
<th>Typical/First Generation Antipsychotics†</th>
<th>Atypical/Second Generation Antipsychotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trifluoperazine (Stelazine®)</td>
<td>Olanzapine/Fluoxetine (Symbyax®)</td>
</tr>
<tr>
<td></td>
<td>Paliperidone (Invega®)*</td>
</tr>
<tr>
<td></td>
<td>Quetiapine (Seroquel®)</td>
</tr>
<tr>
<td></td>
<td>Risperidone (Risperdal®)*</td>
</tr>
<tr>
<td></td>
<td>Ziprasidone (Geodon®)</td>
</tr>
</tbody>
</table>

†Most typical/first generation antipsychotics are available only as generics in the U.S.

*Long-acting injectable formulation available

**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**

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>IM: 150 mg/2 weeks, 300 mg/4 weeks, 210 mg/2 weeks, 405 mg/4 weeks, or 300 mg/2 weeks</td>
<td>405 mg every 4 weeks or 300 mg every 2 weeks</td>
</tr>
</tbody>
</table>

Zyprexa Relprevv should be administered by a healthcare professional.

**VI. Product Availability**

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

**VII. References**

CLINICAL POLICY
Olanzapine Long-Acting Injection

<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Policy split from CP.PHAR.122.LAI Antipsychotics and converted to new template. Removed REMS program and age. Max dose added. Alzheimer’s disease added as an exclusion to the criteria. Appendix B: Oral Antipsychotics – reviewed, edited. Specialist review by psychiatrist.</td>
<td>11.16</td>
<td>12.16</td>
</tr>
<tr>
<td>Converted to new template. Added age restriction per PI/safety approach. Removed “Therapeutic plan includes initial concomitant use of oral antipsychotic therapy as appropriate” since requirement is subjective and specialist is involved in care. Removed requirements related to history of dementia-related psychosis and Alzheimer’s disease per safety approach Increased initial approval duration from 3 to 6 months. Re-auth: updated to allow continuation of therapy for schizophrenia; removed reasons to discontinue per safety approach. Added dementia-related psychosis and Alzheimer’s disease under section III.</td>
<td>08.17</td>
<td>11.17</td>
</tr>
<tr>
<td>3Q 2018 annual review: no significant changes; references reviewed and updated.</td>
<td>05.02.18</td>
<td>08.18</td>
</tr>
</tbody>
</table>

**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.

©2016 Centene Corporation. All rights reserved. All materials are exclusively owned by Centene Corporation and are protected by United States copyright law and international copyright law. No part of this publication may be reproduced, copied, modified, distributed, displayed, stored in a retrieval system, transmitted in any form or by any means, or otherwise published without the prior written permission of Centene Corporation. You may not alter or remove any trademark, copyright or other notice contained herein. Centene® and Centene Corporation® are registered trademarks exclusively owned by Centene Corporation.