Clinical Policy: Olanzapine ODT (Zyprexa Zydis)

Reference Number: CP.PMN.29
Effective Date: 08.01.15
Last Review Date: 02.18
Line of Business: Medicaid

Revision Log

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

Description
Olanzapine ODT (orally disintegrating tablets) (Zyprexa Zydis®) is an atypical antipsychotic.

FDA Approved Indication(s)
Zyprexa Zydis is indicated for the treatment of:

- Schizophrenia in adults and adolescents (ages 13-17)
- Acute manic or mixed episodes associated with bipolar I disorder and maintenance of bipolar I disorder in adults and adolescents (ages 13-17)
- Manic or mixed episodes associated with bipolar I disorder in adults as an adjunct to valproate or lithium
- Depressive episodes associated with bipolar I disorder in adults and children/adolescents (ages 10-17) in combination with fluoxetine
- Treatment-resistant depression in adults in combination with fluoxetine.

Policy/Criteria
Provider must submit documentation (including 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 Zydis is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of schizophrenia;
2. Age ≥ 13 years;
3. Failure of a ≥ 4 week trial of risperidone ODT or oral solution at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Documentation supports member's inability to use regular olanzapine tablets (non-ODT);
5. Dose does not exceed 20 mg/day (1 ODT/day).

Approval duration: 12 months

B. Bipolar Disorder (must meet all)**:**

1. Diagnosis of bipolar disorder;
2. Age ≥ 10 years;

3. Documentation supports member's inability to use regular olanzapine tablets (non-ODT);
4. Dose does not exceed 20 mg/day (1 ODT/day).

Approval duration: 12 months

C. Major Depressive Disorder (must meet all)**:**

1. Diagnosis of major depressive disorder;
2. Age ≥ 18 years;
3. Documentation supports member's inability to use regular olanzapine tablets (non-ODT);
4. Dose does not exceed 15 mg/day (1 ODT/day).

Approval duration: 12 months

D. 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 in Section I (must meet all)**:**

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit;
   b. Documentation supports that member is currently receiving Zyprexa Zydis for schizophrenia or bipolar 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:
   a. Schizophrenia, bipolar disorder: 20 mg/day (1 ODT/day);
   b. Major depressive disorder: 15 mg/day (1 ODT/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 CP.PMN.53 if requested indication is NOT listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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. Dementia-related psychosis.

IV. Appendices/General Information

Appendix A: Abbreviation 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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
risperidone ODT (Risperdal)	2mg – 16mg once or twice daily	Adolescents: 6mg/day Adults: 16mg/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.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Schizophrenia	*Adults* Initial: 5-10 mg PO once daily Target: 10 mg/day *Adolescents* Initial: 2.5-5 mg PO once daily Target: 10 mg/day	20 mg/day
Bipolar I disorder	<u>Manic or mixed episodes</u> *Adults* Monotherapy: 10-15 mg PO once daily Adjunct: 10 mg once daily *Adolescents* Initial: 2.5-5 mg PO once daily Target: 10 mg/day <u>Depressive episodes</u> *Adults* 5 mg Zyprexa Zydis with 20 mg fluoxetine PO once daily *Children and adolescents* 2.5 mg Zyprexa Zydis with 20 mg fluoxetine PO once daily	<u>Manic or mixed episodes</u> 20 mg/day <u>Depressive episodes</u> *Adults*: 15 mg/day* *Children and adolescents*: 10 mg/day*
Treatment-resistant depression	*Adults* 5 mg Zyprexa Zydis with 20 mg fluoxetine PO once daily	15 mg/day*

**Actual maximum dose is 18 mg/day for adults and 12 mg/day for children and adolescents; dose provided in table reflects maximum dose of Zyprexa Zydis per available dosage forms*

VI. Product Availability

ODT (not scored): 5 mg, 10 mg, 15 mg, and 20 mg

VII. Workflow Document

Not available

VIII. References

1. Zyprexa Zydis Prescribing Information. Indianapolis, IN: Lilly USA, LLC; January 2017. Available at: http://pi.lilly.com/us/zyprexa-pi.pdf. Accessed November 2, 2017.
2. Lehman AF, Lieberman JA, Dixon LB, et al. Practice guideline for the treatment of patients with schizophrenia, second edition. Arlington, VA: American Psychiatric Association; February 2004. Available online at http://www.psychiatryonline.org/guidelines. Accessed November 2, 2017.
3. 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 2, 2017.
4. Hirschfeld RMA, Bowden CL, Gitlin MJ, et al. Practice guideline for the treatment of patients with bipolar disorder, second edition. Arlington, VA: American Psychiatric Association; April 2002. Available online at http://www.psychiatryonline.org/guidelines. Accessed November 2, 2017.
5. Hirschfeld RMA. Guideline watch: practice guideline for the treatment of patients with bipolar disorder. Arlington, VA: American Psychiatric Association; November 2005. Available online at http://www.psychiatryonline.org/guidelines. Accessed November 2, 2017
6. Gelenberg AJ, Freeman MP, Markowitz JC, 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 http://www.psychiatryonline.org/guidelines. Accessed November 2, 2017.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New guideline created – replaces CP.PMN.56.	08.15	08.15
Removed requirement for failure of olanzapine tablet and modified criteria to require failure of 2 generic PDL antipsychotics that are FDA approved for schizophrenia and bipolar disorder; Modified criteria D for schizophrenia and bipolar disorder to request for documentation supporting member's inability to use regular olanzapine tablet; For major depressive disorder, removed criteria requiring the use of olanzapine and one generic PDL antipsychotic approved by the FDA for major depressive disorder as there are none. This criterion was replaced by the requirement to try and fail PDL antidepressant medications;	10.15	11.15

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Criteria D for major depression was modified to require documentation supporting member's inability to use regular olanzapine tablet; Updated references.		
Converted to new integrated template. Updated references to include current practice guidelines rather than UpToDate. Removed age restrictions as they are not absolute contraindications per FDA labeling. MDD: Added trial duration of 4 weeks. Removed requirement for trials to be of PDL antidepressants to include any antidepressants.	08.16	11.16
Converted to new template. All indications: Added age limits based on established safety and efficacy per PI. Schizophrenia: Changed requirement of failure of 2 atypical antipsychotics to failure of PDL risperidone ODT or oral solution. Most atypical antipsychotics are available in tablet formulation, and members who cannot use regular olanzapine tablets would likely not be able to trial two other antipsychotics. Bipolar: Removed requirement for failure of 2 atypical antipsychotics for same rationale noted above. Unlike above, risperidone is not added as a required trial as it is not indicated for depressive episodes of bipolar disorder. MDD: Removed the following: "treatment-resistant" from diagnosis language, trial/failure of antidepressants, and requirement for concurrent fluoxetine because regular olanzapine tablets (non-ODT) are available on the PDL without any limitation. Re-auth: Removed MDD from COC criteria as it is not a diagnosis eligible for COC.	07.28.17	11.17
1Q18 annual review: - No significant changes. - References reviewed and updated.	11.13.17	02.18

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.