

/Clinical Policy Title:	Antipsychotics
Policy Number:	RxA.878
Drug(s) Applied:	Caplyta, Fanapt, Cobenfy
Original Policy Date:	04/10/2025
Last Review Date:	12/11/2025
Line of Business Policy Applies to:	All lines of business (except Medicare)

Criteria

I. Initial Approval Criteria

A. Schizophrenia (must meet all):

1. Diagnosis of schizophrenia;
2. Trial and failure for at least 8 weeks total of all the following, unless contraindicated or clinically adverse effects are experienced (a and b):
 - a. Two generic atypical antipsychotics (quetiapine, risperidone, aripiprazole, olanzapine, lurasidone, paliperidone, or ziprasidone);
 - b. Rexulti or Vraylar

Approval duration

All Lines of Business (except Medicare): 12 months

B. Bipolar disorder (Caplyta, Fanapt) (must meet all):

1. Diagnosis of Bipolar disorder;
2. Trial and failure for at least 8 weeks total of all the following, unless contraindicated or clinically adverse effects are experienced (a and b):
 - a. For the diagnosis of Bipolar I: (i and ii)
 - i. Two generic atypical antipsychotics (quetiapine, lurasidone, risperidone, aripiprazole, olanzapine, or ziprasidone)
 - ii. Trial and failure of Vraylar.
 - b. For the diagnosis of Bipolar II: two generic atypical antipsychotics (quetiapine, lurasidone)

Approval duration

All Lines of Business (except Medicare): 12 months

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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

1. Diagnosis of major depressive disorder
2. Will be used as adjunctive therapy with antidepressants
3. Patient has been previously treated with at least three (3) antidepressants from different mechanisms of action, unless contraindicated or adverse effects are experienced:
 - a. Selective serotonin reuptake inhibitors (e.g., sertraline, citalopram)
 - b. Serotonin and norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine)
 - c. Tricyclic antidepressants (e.g., amitriptyline, doxepin)
 - d. Monoamine oxidase inhibitors (e.g., phenelzine, tranylcypromine)
 - e. Bupropion
 - f. Mirtazapine
 - g. Trazodone

Approval duration

All Lines of Business (except Medicare): 12 months

II. Continued Therapy Approval

A. All indications (must meet all):

1. Auto-approval based on lookback functionality within the past 120 days as a proxy for member responding positively to therapy with RxAdvance initial approval.

Approval duration

All Lines of Business (except Medicare): 12 months

References

1. Cobenfy Package Insert. <https://dailymed.nlm.nih.gov/dailymed/getFile.cfm?setid=8f0e73bf-6025-44f6-ab64-0983322de0df&type=pdf>
2. Caplyta package Insert. [label](#)

Review/Revision History	Review/Revised Date	P&T Approval Date
Policy established.	4/10/25	4/10/25
Policy was reviewed: 1. Added bipolar disorder indication	5/21/25	5/21/25
Policy was reviewed: 1. Updated trial and failure for bipolar indication	11/1/2025	N/A
Policy was reviewed: 1. New indication added (Caplyta) MDD	11/12/25	12/11/25