Clinical Policy: Lumateperone (Caplyta)

Reference Number: CP.PMN.232
Effective Date: 03.01.20
Last Review Date: 02.22
Line of Business: Commercial, HIM, Medicaid Revision Log

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

Description

Lumateperone (Caplyta®) is an atypical antipsychotic.

FDA Approved Indication(s)

Caplyta is indicated for the treatment of:

- Schizophrenia in adults
- Depressive episodes associated with bipolar I or II disorder (bipolar depression) in adults, as monotherapy and as adjunctive therapy with lithium or valproate.

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 Caplyta is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

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

1. Diagnosis of schizophrenia;
2. Age ≥ 18 years;
3. Member meets one of the following (a or b):
   a. Failure of two of the following generic atypical antipsychotics at up to maximally indicated doses, each used for ≥ 4 weeks, unless clinically significant adverse effects are experienced or all are contraindicated: risperidone, quetiapine, olanzapine, ziprasidone;
   b. Member has diabetes mellitus or body mass index (BMI) > 30;
4. Failure of a ≥ 4-week trial of aripiprazole at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed 42 mg (1 capsule) per day.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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

1. Diagnosis of bipolar disorder;
2. Age ≥ 18 years;

3. Failure of two preferred atypical antipsychotics (e.g., aripiprazole, ziprasidone, quetiapine, risperidone, or olanzapine) at up to maximally indicated doses, each used for ≥ 4 weeks, unless clinically significant adverse effects are experienced or all are contraindicated;
4. Dose does not exceed 42 mg (1 capsule) per day.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

C. 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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**

1. Currently receiving medication via Centene benefit, or documentation supports that member is currently receiving Caplyta 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 42 mg (1 capsule) per day.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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): CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and 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.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
BMI: body mass index
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
aripiprazole (Abilify®)	**Schizophrenia** Adults: 10 to 15 mg PO QD	30 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	20 mg/day
quetiapine immediate-release (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	800 mg/day
risperidone (Risperdal®)	**Schizophrenia** Initial: 1 mg PO BID or 2 mg PO QD; target: 4 to 8 mg PO QD	Schizophrenia: 16 mg/day
ziprasidone (Geodon®)	**Schizophrenia** 20 mg PO BID	160 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 lumateperone or any components of Caplyta
- Boxed warning(s): increased mortality in elderly patients with dementia-related psychosis; suicidal thoughts and behaviors

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Schizophrenia	42 mg PO QD	42 mg/day

VI. Product Availability
Capsule: 42 mg

VII. References
1. Caplyta Prescribing Information. New York, NY: Intra-Cellular Therapies, Inc.; December 2021. Available at: www.caplyta.com. Accessed January 4, 2022.

2. Keepers GA, Fochtmann LJ, Anzia JM, et al. The American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia. The American Psychiatric Association, December 2019. Available at: https://www.psychiatry.org/psychiatrists/practice/clinical-practice-guidelines. Accessed January 8, 2020.
3. Keepers G, Fochtmann L, Anzia J, et al. APA Practice guideline for the treatment of patients with schizophrenia, third edition. Am J Psychiatry. 2020 Sept;177(9):868-872.
4. Kadakia A, Dembek C, Heller V, et al. Efficacy and tolerability of atypical antipsychotics for acute bipolar depression: a network meta-analysis. BMC Psychiatry. May 2021;21, 249. Available at: https://bmcpsychiatry.biomedcentral.com/articles/10.1186/s12888-021-03220-3#article-info. Accessed January 4, 2022.
5. Yatham LN, Kennedy SH, Parikh SV, et al. Canadian Network for Mood and Anxiety Treatments (CANMAT) and International Society for Bipolar Disorders (ISBD) 2018 guidelines for the management of patients with bipolar disorder. Bipolar Disord. 2018;20:97–170. https://doi.org/10.1111/bdi.12609.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01.14.20	02.20
1Q 2021 annual review: no significant changes; references to HIM.PHAR.21 revised to HIM.PA.154; references reviewed and updated.	11.29.20	02.21
1Q 2022 annual review: no significant changes; revised Commercial auth limit from Length of Benefit to 12 months or duration of request whichever is less; RT4: added criteria for the recently FDA-approved indication of bipolar depression; references reviewed and updated.	11.13.21	02.22

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.