

Pre - PA Allowance

None

Prior-Approval Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Hallucinations and/or delusions associated with Parkinson's disease psychosis

AND ALL of the following:

1. Submission of medical records (e.g. chart notes, laboratory values) documenting an inadequate treatment response, intolerance, or contraindication to quetiapine
2. Submission of medical records (e.g. chart notes, laboratory values) documenting the presence of hallucinations or delusions (which may include illusions or a false sense of presence) on a recurrent or continuous basis for at least 1 month
3. Submission of medical records (e.g. chart notes, laboratory values) documenting the prescribing physician has attempted to adjust Parkinson's disease medications in order to reduce psychosis without worsening motor symptoms prior to requesting Nuplazid
4. Used in combination with another Parkinson's disease medication
5. **NOT** to be used to treat psychiatric symptoms attributed to Alzheimer disease, schizophrenia, schizoaffective disorder or delusional disorder
6. Prescriber agrees to monitor for QTc prolongation

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Prior - Approval Limits

Quantity

Medication	Quantity Limit
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**NUPLAZID
(pimavanserin)**

10 mg	90 tablets per 90 days OR
34 mg	90 capsules per 90 days

Duration 6 months

Prior – Approval *Renewal* Requirements

Age 18 years of age or older

Diagnosis

Patient must have the following:

Hallucinations and/or delusions associated with Parkinson’s disease psychosis

AND ALL of the following:

1. Submission of medical records (e.g. chart notes, laboratory values) documenting that the patient has been assessed for improvement on therapy
2. Used in combination with another Parkinson’s disease medication
3. **NOT** to be used to treat psychiatric symptoms attributed to Alzheimer disease, schizophrenia, schizoaffective disorder or delusional disorder
4. Prescriber agrees to continue to monitor for QTc prolongation

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Prior - Approval *Renewal* Limits

Quantity

Medication	Quantity Limit
10 mg	90 tablets per 90 days OR
34 mg	90 capsules per 90 days

Duration 12 months