Effective Date: 02/01/2021
Reviewed: 11/2020, 07/2021, 9/2021, 5/2022, 1/2023 Scope: Medicaid

Vraylar (cariprazine)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 12 months may be granted when all the following criteria are met:

Schizophrenia

A. The member is being treated for schizophrenia; AND
B. The member has experienced a failure, contraindication, or intolerance to at least three formulary atypical antipsychotics (i.e., Aripiprazole, Olanzapine, Quetiapine IR or ER, Risperidone, or Ziprasidone)

Bipolar disorder

A. The member is being treated for bipolar disorder; AND
B. The member has experienced a failure, contraindication or intolerance to all of the following: Olanzapine, Quetiapine IR or ER, and Latuda.

Major Depressive Disorder (MDD)

A. The member is being treated for adjunctive therapy for the treatment of MDD; AND
B. The member has experienced a failure, contraindication or intolerance to aripiprazole

II. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for all members who have documentation of a positive clinical response.

III. QUANTITY LIMIT

- Vraylar 1.5mg or 3mg: 60 tablets per 30 days
- Vraylar 4.5mg or 6mg: 30 tablets per 30 days

IV. COVERAGE DURATION

- 12 months