Mass General Brigham
Health Plan

Atypical Antipsychotics
Effective 03/01/2026

Plan	☐ MassHealth UPPL ☒Commercial/Exchange	**Program Type**	☐ Prior Authorization ☐ Quantity Limit ☒ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit		
Specialty Limitations	N/A		
Contact Information	**Medical Benefit** **Pharmacy Benefit**	Phone: 833-895-2611 Phone: 800-711-4555	Fax: 888-656-6671 Fax: 844-403-1029
Exceptions	N/A		

Overview
Prescriptions that meet the initial step therapy requirements will adjudicate automatically at the point of sale. If the prescription does not meet the initial step therapy requirements, the prescription will deny with a message indicating that prior authorization (PA) is required. Refer to the criteria below and submit a PA request for the members who do not meet the initial step therapy requirements at the point of sale.

Initial Step-Therapy Requirements:
First-Line: Medications listed on first-line are covered without prior-authorization.
Second-Line: Second-line medications will pay if the member has filled at least one first-line or one second-line medication within the past 180 days
Third-Line: Third-line medications will pay if the member has filled at least one second-line or one third-line medication in the past 180 days

FIRST-LINE	SECOND-LINE	THIRD-LINE
Aripiprazole tablet, oral solution, ODT Asenapine SL tablet Clozapine tablet, ODT lurasidone tablet olanzapine tablet, ODT quetiapine tablet quetiapine extended-release tablet risperidone tablet, oral solution, ODT ziprasidone capsule	paliperidone tablet Rexulti (brexpiprazole) tablets Vraylar (cariprazine) capsules	Caplyta (lumateperone) capsules Fanapt (iloperidone) tablet Lybalvi (olanzapine/ samidorphan) tablet Secuado (asenapine) transdermal patch

Erzofri (paliperidone extended-release) injection is indicated for the treatment of:

- Schizophrenia in adults

- Schizoaffective disorder in adults as monotherapy and as an adjunct to mood stabilizers or antidepressants

Erzofri requires prior authorization and is not part of the antipsychotic step therapy program.

For all second- and third-line agents in the antipsychotic step therapy program, if a member does not meet the initial step therapy requirements, then approval of a second- or third-line medication will be granted if the member meets the criteria listed below.

Coverage Guidelines

Authorization may be granted for members new to the plan within the past 90 days who are currently receiving treatment with the requested medication, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted for members when all the following criteria have been met:

Paliperidone tablets

1. Member meets ONE of the following:
    a. Member has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)
    b. Member has had an inadequate response or intolerance to one of the following medications or clinical rationale why none of the following medications is appropriate for the member:
        i. Aripiprazole tablet, oral solution, orally disintegrating tablet
        ii. Asenapine sublingual tablet
        iii. Clozapine tablet, orally disintegrating tablet
        iv. Lurasidone tablet
        v. Olanzapine tablet, orally disintegrating tablet
        vi. Quetiapine immediate-release or extended-release tablet
        vii. Risperidone tablet, oral solution, orally disintegrating tablet
        viii. Ziprasidone capsule
        ix. Rexulti (brexpiprazole) tablet
        x. Vraylar (cariprazine) capsule
    c. Member has a diagnosis of schizoaffective disorder
    d. Member has a diagnosis of schizophrenia and is 12 years of age or younger

Rexulti (brexpiprazole) tablet

1. Member meets ONE of the following:
    a. Member has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)
    b. Member has had an inadequate response or intolerance to one of the following medications or clinical rationale why none of the following medications is appropriate for the member:
        i. Aripiprazole tablet, oral solution, orally disintegrating tablet
        ii. Asenapine SL tablet
        iii. Clozapine tablet, orally disintegrating tablet
        iv. Lurasidone tablet

v. Olanzapine tablet, orally disintegrating tablet
vi. Paliperidone extended-release tablet
vii. Quetiapine immediate-release or extended-release tablet
viii. Risperidone tablet, oral solution, orally disintegrating tablet
ix. Ziprasidone capsule
x. Vraylar (cariprazine) capsule

c. Member has a diagnosis of agitation in association with dementia due to Alzheimer's disease

Vraylar (cariprazine) capsule

1. Member meets ONE of the following:
    a. Member has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)
    b. Member has had an inadequate response or intolerance to one of the following medications or clinical rationale why none of the following medications is appropriate for the member:
        i. Aripiprazole tablet, oral solution, orally disintegrating tablet
        ii. Asenapine SL tablet
        iii. Clozapine tablet, orally disintegrating tablet
        iv. Lurasidone tablet
        v. Olanzapine tablet, orally disintegrating tablet
        vi. Paliperidone extended-release tablet
        vii. Quetiapine immediate-release or extended-release tablet
        viii. Risperidone tablet, oral solution, orally disintegrating tablet
        ix. Ziprasidone capsule
        x. Rexulti (brexpiprazole) tablet

Caplyta (lumateperone) capsule

1. Member meets ONE of the following:
    a. Member has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)
    b. Member has had an inadequate response or intolerance to one of the following medications or clinical rationale why none of the following medications is appropriate for the member:
        i. Rexulti (brexipiprazole) tablet
        ii. Vraylar (cariprazine) capsule
        iii. Paliperidone extended-release tablet
        iv. Fanapt (iloperidone) tablet
        v. Secuado (asenapine) transdermal patch
        vi. Lybalvi (olanzapine/samidorphan) tablet
    c. Member has a diagnosis of bipolar II depression and meets ONE of the following:
        i. Member has had an inadequate response or intolerance to quetiapine
        ii. Member is using Caplyta as an adjunct to lithium or valproate

Fanapt (iloperidone) tablet

1. Member meets ONE of the following:

a. Member has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)
b. Member has had an inadequate response or intolerance to one of the following medications or clinical rationale why none of the following medications is appropriate for the member:
    i. Rexulti (brexipiprazole) tablet
    ii. Vraylar (cariprazine) capsule
    iii. Paliperidone extended-release tablet
    iv. Caplyta (lumateperone) capsule
    v. Secuado (asenapine) transdermal patch
    vi. Lybalvi (olanzapine/samidorphan) tablet

Secuado (asenapine) transpdermal patch

1. Member meets ONE of the following:
    a. Member has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)
    b. Member has had an inadequate response or intolerance to one of the following medications or clinical rationale why none of the following medications is appropriate for the member:
        i. Rexulti (brexipiprazole) tablet
        ii. Vraylar (cariprazine) capsule
        iii. Paliperidone extended-release tablet
        iv. Caplyta (lumateperone) capsule
        v. Fanapt (iloperidone) tablet
        vi. Lybalvi (olanzapine/samidorphan) tablet

Lybalvi (olanzapine/samidorphan) tablet

1. Member meets ONE of the following:
    a. Member has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)
    b. Member has had an inadequate response or intolerance to one of the following medications or clinical rationale why none of the following medications is appropriate for the member:
        i. Rexulti (brexipiprazole) tablet
        ii. Vraylar (cariprazine) capsule
        iii. Paliperidone extended-release tablet
        iv. Caplyta (lumateperone) capsule
        v. Fanapt (iloperidone) tablet
        vi. Secuado (asenapine) transdermal patch
    c. Member is being treated for maintenance of bipolar I disorder manic or mixed episodes and has had an inadequate response or intolerance to BOTH of the following medications or clinical rationale why none of the following medications is appropriate for the member:
        i. Asenapine sublingual tablet
        ii. Olanzapine tablet, orally disintegrating tablet

Erzofri (paliperidone palmitate) extended-release injection

1. Member meets ONE of the following:
    a. Member has been started and stabilized on the requested medication (samples are not considered adequate justification for started & stabilized)
    b. Member has had an inadequate response or intolerance to one of the following medications or clinical rationale why none of the following medications is appropriate for the member:
        i. Invega Sustenna
        ii. Invega Trinza
        iii. Invega Hayfera

Limitations

1. Approvals will be granted for 36 months.
2. The following quantity limits apply:

Drug Name	Quantity Limit
Abilify Maintena	1 syringe per 28 days
Aripiprazole solution 1mg/ml	150ml per 30 days
Aripiprazole tablets 15mg, 20mg, & 30mg	30 tablets per 30 days
Aripiprazole tablets 2mg, 5mg, & 10mg	60 tablets per 30 days
Aripiprazole tablets ODT	30 tablets per 30 days
Asenapine SL tablet	60 tablets per 30 days
Caplyta 42mg capsules	30 capsules per 30 days
Clozapine tablets 100mg	270 tablets per 30 days
Clozapine tablets 25mg	90 tablets per 30 days
Clozapine tablets 50mg	135 tablets per 30 days
Erzofri extended-release injection	1 syringe per 28 days
Fanapt tablets	60 tablets per 30 days Fanapt starter pack can be filled one time.
Invega Sustenna	1 syringe per 28 days
Invega Trinza	1 syringe per 84 days
Lurasidone tablets 20mg, 40mg, 60mg, & 120mg	30 tablets per 30 days
Lurasidone tablets 80mg	60 tablets per 30 days
Lybalvi tablets 5mg/10mg, 10 mg/10mg, 15mg/10mg, 20mg/10mg	30 tablets per 30 days
Olanzapine tablets 2.5mg & 5mg	60 tablets per 30 days
Olanzapine tablets 7.5mg, 10mg, 15mg, & 20mg	30 tablets per 30 days
Olanzapine tablets ODT	30 tablets per 30 days
Paliperidone tablets ER 1.5mg, 3mg, & 6mg	30 tablets per 30 days
Paliperidone tablets ER 9mg	60 tablets per 30 days
Quetiapine tablets 25mg	120 tablets per 30 days
Quetiapine tablets 300mg & 400mg	60 tablets per 30 days
Quetiapine tablets 50mg, 100mg, & 200mg	90 tablets per 30 days
Quetiapine tablets ER 150mg & 200mg	30 tablets per 30 days

Quetiapine tablets ER 50mg, 300mg, & 400mg.	60 tablets per 30 days
Rexulti tablets 0.25mg, 0.5mg, & 1mg	30 tablets per 30 days
Rexulti tablets 2mg, 3mg, & 4mg	60 tablets per 30 days
Risperdal Injection 12.5mg	2 injection kits per 28 days
Uzedy injection	1 injection per 28 days
Vraylar capsules 1.5mg	60 tablets per 30 days
Vraylar capsules 3mg, 4.5mg, & 6mg	30 tablets per 30 days
Zyprexa Relprevv	2 vials per 28 days

References

1. Abilify (aripiprazole) [prescribing information]. Rockville, MD: Otsuka America Pharmaceutical Inc; February 2018
2. Abilify Maintena® [package insert].Rockville (MD): Otsuka America Pharmaceutical, Inc.; 2015 Jul.
3. Caplyta (lumateperone) [prescribing information]. Bedminster, NJ: Intra-Cellular Therapies Inc; November 2025.
4. Fanapt (iloperidone) [prescribing information]. Washington, DC: Vanda Pharmaceuticals Inc; February 2017
5. Invega (paliperidone) [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals; July 2018
6. Invega Sustenna (paliperidone palmitate) extended-release injectable suspension [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals; July 2018
7. Latuda (lurasidone) [prescribing information]. Marlborough, MA: Sunovion Pharmaceuticals Inc; March 2018
8. Rexulti (brexpiprazole) [prescribing information]. Rockville, MD: Otsuka America Pharmaceutical; February 2018
9. Risperdal (risperidone) tablets, oral solution, and orally disintegrating tablets [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals Inc; July 2018.
10. Risperdal Consta (risperidone) long-acting injection [prescribing information]. Titusville, NJ: Janssen Pharmaceuticals Inc; July 2018
11. Saphris (asenapine) [prescribing information]. Irvine, CA: Allergan USA Inc; January 2017
12. Secuado (asenapine) [prescribing information]. Miami, FL: Noven Therapeutics, LLC; October 2019.
13. Seroquel (quetiapine) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; November 2018.
14. Seroquel XR (quetiapine) [prescribing information]. Wilmington, DE: AstraZeneca Pharmaceuticals LP; November 2018
15. Vraylar (cariprazine) [prescribing information]. North Chicago, IL: Abbvie; December 2025.
16. Zyprexa (olanzapine) [prescribing information]. Indianapolis, IN: Lilly USA LLC; March 2018
17. Zyprexa Relprevv (olanzapine) [prescribing information]. Indianapolis, IN: Lilly USA; March 2018.

Review History

09/24/2007 – Reviewed
09/22/2008 – Update approval to 36 months
09/21/2009 – Reviewed
09/24/2009 – Updated
10/26/2009 – 1.5mg strength and injection
06/21/2010 – Updated
12/15/2010 – Disclaimer

06/27/2011 – Reviewed
02/03/2012 – Olanzapine & MHP notification of Zydis MSC override
04/02/2012 – Geodon & Seroquel generic name changes
03/01/2013 – ST/QL program update to review in CCC; QL for clozapine 50mg tabs; increase risperidone ODT QLs)
07/22/2013 – Abilify Maintena inclusion
11/24/2014 – Updated
06/08/2015 – Abilify tabs generic
08/03/2015 – Invega Trinza added
10/01/2015 – Abilify oral soln generic & Invega generic
11/23/2015 – Reviewed
06/22/2016 – Added Rexulti and Vraylar
11/27/2017 – Reviewed
06/19/2019 – Reviewed
02/27/2020 – additional of Secuado patches to second line
01/20/2021 – Reviewed and updated; added Caplyta as second line agent; added QL for Caplyta; references updated. Effective 02/01/21.
01/19/2022 – Reviewed and Updated; added new medication Invega Hafyera as first line agent. Effective 04/01/2022.
09/13/2023 – Reviewed and Updated for Sept P&T; added new medication Uzedy and Abilify Asumtifii as first line agent. Effective 11/1/23.
02/12/2025 - Reviewed and updated for February P&T. Updated policy to reflect changes to step therapy program: aripiprazole tablet/oral solution/ODT, asenapine SL tablet, clozapine tablet/ODT, lurasidone tablet, olanzapine tablet/ODT, quetiapine IR tablet, quetiapine ER tablet, risperidone tablet/oral solution/ODT, ziprasidone capsule will be first line; paliperidone ER tablet, Rexulti tablet and Vraylar capsule will be second line; Caplyta, Fanapt, Lybalvi and Secuado will be third line. First line agents are covered without PA, second line agents will pay at the pharmacy if there is a claim in the past 180 days for one first-line or one second-line agent. Third-line agents will pay at the pharmacy if there is a claim in the past 180 days for one second-line or one third-line agent. Prior authorization criteria reflect automatic step requirements, with specific criteria for diagnoses not shared with lookback agents. PA criteria for Erzofri was added to the policy. Effective 05/01/2025.
02/11/2026 – Reviewed at February P&T. No clinical changes. Effective 03/01/2026.