Los Angeles County
DEPARTMENT OF MENTAL HEALTH

Christy Doan, Pharm.D., MBA
Interim Pharmacy Services Chief
Pharmacy and Laboratory Services

September 4, 2018

TO: All DMH Supervising Psychiatrists
All DMH Program Heads
All DMH and Legal Entity Prescribers
All DMH Nurses

FROM: Christy Doan, Pharm.D., MBA
Interim Pharmacy Services Chief

SUBJECT: **LONG ACTING INJECTABLES CRITERIA USE**

This memo is being written to notify all DMH prescribers the changes with long acting injectables (LAI).

The following LAIs are now part of the DMH formulary: Aristada, Abilify Maintena, and Invega Sustenna. Per Policy 306.03, formulary psychotropic pharmaceutical samples may be stored and utilized in LACDMH programs. Non-formulary psychotropic pharmaceutical samples cannot be stored and/or dispensed at any LACDMH programs.

Below is a detailed summary of each LAI's criteria use:

Aristada – Preferred Formulary
Criteria Use

Initial

1. Client is at least 18 years of age; AND
2. Must have a diagnosis of Schizophrenia; AND
3. Client has history of poor adherence to oral antipsychotics; AND
4. If client is receiving medications that require dose modifications, clinical information is submitted; AND
5. Two (2) non-LAI formulary antipsychotics have been tried and failed.

Renewal

1. If client did not receive Aristada Initio, oral aripiprazole has been tapered and discontinued after stabilization within the last 30 days, since treatment with Aristada; AND
2. Client is compliant with Aristada; AND
3. Client has shown measurable improvement in target symptoms since therapy was initiated; AND
4. If client is receiving medications that require dose modifications, clinical information is submitted.

Abilify Maintena – Restricted Formulary, PA required
Criteria Use

Initial

1. Client is at least 18 years of age; AND
2. Must have a diagnosis of Schizophrenia or Bipolar I Disorder; AND
3. Client has tolerated at least 14 days of oral aripiprazole; AND
4. Client has history of poor adherence to oral antipsychotics; AND
5. If client is receiving medications that require dose modifications, clinical information is submitted; AND
6. Two (2) non-LAI formulary antipsychotic agents have been tried and failed; AND
7. Preferred formulary LAI has been tried and failed.

Renewal

1. Oral aripirazole has been tapered and discontinued after stabilization period within the last 30 days, since treatment with Abilify Maintena began; AND
2. Client has shown measurable improvement in target symptoms since therapy was initiated; AND
3. Client is compliant with Abilify Maintena; AND
4. If client is receiving medications that require dose modifications, clinical information is submitted; AND
5. Preferred formulary LAI has been tried and failed.

Invega Sustenna – Restricted Formulary, PA required
Criteria Use

Initial

1. Client is at least 18 years of age; AND
2. Must have a diagnosis of Schizophrenia or Schizoaffective disorder; AND
3. Client can tolerate at least 2mg per day of oral risperidone or 3mg per day of oral Invega; AND
4. Client does NOT have severe renal disease and is NOT on dialysis; AND
5. Client has history of poor adherence to oral antipsychotics; AND
6. If client is receiving medications that require dose modifications, clinical information is submitted; AND
7. Two (2) non-LAI formulary antipsychotic agents have been tried and failed; AND
8. Preferred formulary LAI has been tried and failed.

Renewal

1. Client has NOT been on other antipsychotic drugs for more than 60 days since treatment with Invega Sustenna or Risperdal Consta began; AND
2. Client does NOT have severe renal disease and is NOT on dialysis; AND

3. Client has shown measurable improvement in target symptoms since therapy was initiated; AND
4. Client is compliant with Invega Sustenna; AND
5. If client is receiving medications that require dose modifications, clinical information is submitted; AND
6. Preferred formulary LAI has been tried and failed.

Hypersensitivity (allergy), adverse response, or ineffectiveness to oral antipsychotics is not a reason for approval. The provider should try other formulary oral antipsychotic agents.

Please address any question(s) or concern(s) to Pharmacy Services (213) 738-4725. Thank you.