

## **Clinical Policy: Clozapine Orally Disintegrating Tablet (Fazacllo)**

Reference Number: CP.PMN.12

Effective Date: 08.01.15

Last Review Date: 02.19

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Clozapine orally disintegrating tablet (Fazacllo<sup>®</sup>) is an atypical antipsychotic.

### **FDA Approved Indication(s)**

Fazacllo is indicated for:

- Treatment-resistant schizophrenia
- Reducing suicidal behavior in patients with schizophrenia or schizoaffective disorder

### **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<sup>®</sup> that Fazacllo is **medically necessary** when the following criteria are met:

## **I. Initial Approval Criteria**

### **A. Schizophrenia or Schizoaffective Disorder** (must meet all):

1. Diagnosis of schizophrenia or schizoaffective disorder;
2. Age  $\geq$  18 years;
3. Failure of a  $\geq$  4 week trial of risperidone orally disintegrating tablet or solution at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
4. Medical justification supports member's inability to use regular (non-orally disintegrating) clozapine tablets;
5. Dose does not exceed 900 mg per day.

**Approval duration: 12 months**

### **B. 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.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 Fazacllo for schizophrenia or schizoaffective 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 900 mg per day.

**Approval duration: 12 months**

**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 6 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.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 policy – CP.PMN.53 or evidence of coverage documents.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

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 and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
risperidone orally disintegrating tablet (Risperdal <sup>®</sup> )	2 mg to 16 mg PO QD to BID	16 mg/day

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

*Appendix C: Contraindications/Boxed Warnings*

- Contraindication(s): Known serious hypersensitivity to clozapine or any other component of Fazaclo
- Boxed warning(s):
  - Severe neutropenia: Clozapine can cause severe neutropenia, which can lead to serious and fatal infections. Patients initiating and continuing treatment with Fazaclo must have a baseline blood absolute neutrophil count measured before treatment initiation and regular absolute neutrophil count monitoring during treatment.
  - Fazaclo is available only through a restricted program called the Clozapine REMS.
  - Orthostatic hypotension, bradycardia, and syncope: Risk is dose related. Starting dose is 12.5 mg. Titrate gradually and use divided dosages.
  - Seizure: Risk is dose-related. Titrate gradually and use divided doses. Use with caution in patients with history of seizure or risk factors for seizure.

- Myocarditis and cardiomyopathy: Can be fatal. Discontinue and obtain cardiac evaluation if findings suggest these cardiac reactions.
- Increased mortality in elderly patients with dementia-related psychosis: Fazacllo is not approved for this condition.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Schizophrenia/schizoaffective disorder	12.5 mg PO QD or BID. Titrate the total daily dosage in increments of 25 mg to 50 mg per day, to a target dose of 300 mg to 450 mg per day, in divided doses, by the end of 2 weeks.	900 mg/day

**VI. Product Availability**

Orally disintegrating tablets: 12.5 mg, 25 mg, 100 mg, 150 mg, 200 mg

**VII. References**

1. Fazacllo Prescribing Information. Palo Alto, CA: Jazz Pharmaceuticals, Inc.; February 2017. Available at: <http://pp.jazzpharma.com/pi/fazacllo.en.USPI.pdf>. Accessed October 30, 2018.
2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2018. Available at: [www.clinicalpharmacology-ip.com](http://www.clinicalpharmacology-ip.com).
3. Clozapine REMS Web site. <https://www.clozapinerems.com/>. Accessed October 30, 2018.
4. Lehman AF, Lieberman JA, Dixon LB et al. Practice guideline for the treatment of patients with schizophrenia, second edition. Am J Psychiatry. 2004 Feb;161(2 Suppl):1-56.
5. American Psychiatric Association: Guideline Watch (September 2009): Practice Guideline for the Treatment of Patients with Schizophrenia, 2009. <http://psychiatryonline.org/guidelines>. Accessed October 30, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New guideline created – replaces CP.PMN.56	08.15	08.15
Removed requirement for failure of clozapine tablet and modified criteria to require failure of 2 generic PDL agents FDA approved for member’s diagnosis; Modified criteria D to request for documentation supporting member’s inability to use regular clozapine tablet	10.15	11.15
Converted to new integrated template; updated references	08.16	11.16
1Q18 annual review: No significant changes; References reviewed and updated.	11.02.17	02.18
1Q 2019 annual review: no significant changes; references reviewed and updated.	10.30.18	02.19

**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.

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**Note: For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence.

**CLINICAL POLICY**  
**Clozapine Orally Disintegrating Tablet**



Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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