



## Prior Authorization Approval Criteria

### *Latuda (lurasidone)*

<b>Generic name:</b>	lurasidone
<b>Brand name:</b>	Latuda
<b>Medication class:</b>	Atypical antipsychotic
<b>FDA-approved uses:</b>	For use in adults with schizophrenia.
<b>Usual dose range:</b>	<b>40mg once daily. Maximum daily dose is 80mg/day</b>
<b>Approximate monthly cost:</b> (based on AWP 2011)	<b>\$504.00/month</b>
<b>Duration of therapy:</b>	Indefinite

**Criteria for use** (*bullet points below are all inclusive unless otherwise noted*):

- The indicated diagnosis (including any applicable labs and /or tests) and medication usage must be supported by documentation from the patient's medical records.
- Must be clinically diagnosed with Schizophrenia.
- Must be 18 years of age or older.
- Must have tried and failed or been intolerant to at least 2 formulary atypical antipsychotic agents

**Contraindications:**

- Known hypersensitivity to Latuda or any components in the formulation.
- Co-administration with a strong CYP3A4 inhibitor and inducer.

**Not approved if:**

- Patient has any contraindications to the use of Latuda.
- Patient does not meet the above stated criteria.
- Patient has dementia-related psychosis.

**Special considerations:**

**Black box warning:**

- Elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo.

FCHP Pharmacy and Therapeutics Committee approval: \_\_\_\_\_

Date: \_\_\_\_\_

Adopted: 03/09/11