



NAMI has developed a range of talking points in response to the NASMHPD Medical Directors Council’s Statement on Antipsychotic Prescribing. These can be used, depending on individual state circumstances, to preserve open access policies, reject highly restrictive policies, and advocate for greater access and patient protections. We urge you to examine your current state policies on antipsychotic prescribing, as well as any likely or existing proposals for policy changes, and utilize talking points that best meet your needs.

Preferred Drug Lists and Utilization Management

The Council’s minimum recommendations for a preferred drug list would restrict access to some antipsychotics. Other Council recommendations warn against overly restrictive policies and state the need for consumer protections. The common experience of consumers and prescribers, however, is that these important protections are absent or inadequately enforced, with often disastrous results for persons living with serious mental illness.

Talking Point: Unrestricted access to antipsychotics is most clinically desirable.

The Medical Directors Council makes the important point that an open formulary with unrestricted access to all antipsychotic medications is clinically desirable. The Council discusses many considerations that inform clinical decision-making, including side effects, efficacy, and individual preferences and vulnerabilities. The statement expressly acknowledges that there is no best medication or dose for all patients.

Talking Point: States historically fail to “reinvest savings” into funding for other mental health services.

In claiming that resources saved in prescribing antipsychotic medications can be reinvested in other mental health services, the Medical Directors Council fails to recognize that states have a long record of failing to reinvest program savings, most notably from the downsizing and closure of state hospitals, into housing and community-based services. The experience of NAMI members for more than 40 years is that savings frequently disappear altogether from already underfunded and fragmented mental health systems.

Talking Point: At minimal levels, preferred drug list recommendations restrict needed medications.

The Medical Directors Council proposes that a PDL, if used, should include a minimum of at least *one* antipsychotic in each of seven classes with clinically significant differences. At minimal levels (one in each class), some atypical anti-psychotic medications would be excluded from a preferred drug list, leaving as few as three or four of the atypical antipsychotics as open access medications (See Table 2). This means that if a consumer and his or her doctor needs a medication that is not on the PDL, they would have to go through a prior authorization process before they could get the medication.

| Table 2 Categories of Antipsychotics from NASMHPD Medical Directors Council Statement | | | | | | |
|--|--|--|--|------------------------------|---------------------------|---|
| Relatively Sedating Atypicals | Relatively Weight-Neutral Atypicals | High Potency Atypicals | Clozapine (Medication-specific category) | Low-Potency Typical | Medium Potency Typical | High Potency Typical with Long-Acting Formulations |
| Possible Antipsychotics for each Category | | | | | | |
| Seroquel/ quetiapine Zyprexa/ olanzapine | Abilify/ aripiprazole Geodon/ ziprasidone | Invega/ paliperidone Risperdal/ risperidone Zyprexa/ olanzapine | Clozaril/ clozapine | Thorazine/ chlorpromazine | Trilafon/ Perphenazine | Haldol/ haloperidol Prolixin/ fluphenazine |



Talking Point: Highly restrictive and “fail first” policies should be rejected.

The Council’s recommendations reject policies that limit preferred drug lists to a single atypical antipsychotic medication. They also reject step therapy policies that require a trial of an older medication first before a newer medication can be tried or require a trial of one type of medication on the list before another medication is allowed. Advocates in states considering restrictive policies of this kind should argue that these policies are not supported by science.

Talking Point: NAMI advocates for no prior authorization of antipsychotics. If prior authorization is implemented, processes must be “responsive, user-friendly, and timely.”

Prior authorization procedures or processes for accessing medications can present significant, even overwhelming, challenges for consumers and result in individuals not getting the medications they need. The Medical Directors Council emphasizes that prior authorization processes should be “simple and flexible.” Yet, the Council fails to provide any model or examples of consumer and prescriber-friendly processes. It is critical that states create clearly defined processes that consumers and prescribers agree are user-friendly, timely, and flexible. Performance measures for these processes are also necessary.

Talking Point: Independent assessment of the effect of prior authorization on consumer outcomes must be required.

Research on preferred drug lists and restrictive prior authorization and utilization management practices suggest they result in negative outcomes for consumers with mental illness.^{1,2} Any restrictions in coverage of antipsychotics in formularies or preferred drug lists must include relevant data collection and independent assessment evaluating the effect on consumer outcomes.

Talking Point: Improving prescribing practices for antipsychotics should be the focus of any utilization management program.

The Medical Directors Council recommends that promotion of best prescribing practices should be the major focus of management of medications. With the majority of mental health medications prescribed by primary care doctors who frequently have inadequate knowledge or experience in prescribing antipsychotic medications, such programs have the potential to improve consumer outcomes.

Continuity of Care

Advocates can use several recommendations of the Medical Directors Council to ensure that consumers who have responded to a medication in the past or are currently responding to a medication are able to continue to receive that medication.

Talking Point: Medications that work or have worked in the past must be continued.

The Medical Directors Council states that a medication that is or has been safe and effective for a patient should be available to them. The recommendations support “grandfathering” people who are doing well on a medication to reduce relapse and support continuity of care.

Talking Point: Clinical decisions should be made by a consumer and his or her doctor, not a bureaucrat.

Decisions about past clinical response or clinical necessity for a non-preferred medication should take into account past treatment history, other medical conditions, potential drug interactions, patient preferences, side effects, tolerability and other important clinical factors. These clinical decisions should be made by a consumer and his or her doctor—not a governmental entity—and should not result in burdensome administrative requirements.



Talking Point: Formulary policies must be aligned to ensure continuity of care for consumers across payers and plans.

The Medical Directors Council emphasizes that consumers should not be forced to switch medications due to changes in formulary policy, prior authorization, or change in payer. The statement adds that this will require coordination and flexibility across plans and payers.

In some states, state hospitals have a different formulary than the state Medicaid program. This can result in troubling, even tragic, discontinuity of care when individuals transition to the community. Jails and prisons also typically have different formularies than Medicaid, leading to medication switches or even discontinuation of medications, often with disastrous results.

This powerful recommendation of the Medical Directors Council can be used by advocates to support flexible access to medications across plans and payers (including different state and local agencies) in order to facilitate continuity of care.

Treatment Non-Adherence

Non-adherence to treatment is a significant problem for people with schizophrenia. The CATIE study reported that 74% of consumers in the trials stopped taking their antipsychotic medications. The reasons for non-adherence are many and may include the intolerable side effects of a particular medication, alleviation of symptoms making a consumer feel that she or he doesn't need medications anymore, or anosognosia, a common clinical phenomena where an individual does not realize they are ill and need treatment.

NAMI is concerned that restrictive drug policies may have the effect of further limiting adherence if consumers are forced to jump through hoops to access medications prescribed by their doctors.

Talking Point: Restrictive access to medications may impair treatment adherence.

Failure to respond to or continue an antipsychotic may lead to a devastating relapse. A psychotic episode can result in cognitive impairment, emergency department visits, hospitalization—or even homelessness, incarceration or suicide. The harmful, even fatal, consequences of treatment non-adherence illustrate the critical need to make available any antipsychotic that may be helpful and acceptable to a consumer living with schizophrenia or other serious mental illness.

Talking Point: Medication adherence should be promoted through shared decision-making between consumers and their doctors.

The Medical Directors Council recommends improving medication adherence by promoting shared decision-making, a recovery-oriented approach, community case management, and education of consumers and families. This recommendation can be particularly helpful in states that are lacking case management and educational programs for consumers and families or where restrictive medication policies have interfered with shared decision-making between clinicians and consumers.

Additional Resource

- Dr. Kenneth Duckworth and Michael Fitzpatrick's article, *NAMI Perspective on CATIE: Policy and Research Implications* (May 2008). Available to subscribers at <http://psychservices.psychiatryonline.org> or contact NAMI for a copy.

1 Soumerai, Stephen B., Zhang, Fang, Ross-Degnan, Dennis, et al, Use of atypical antipsychotic drugs for schizophrenia in Maine Medicaid following a policy change. *Health Affairs* 27, no. 3 (2008), w185-w195.

2 West, Joyce C., Wilk, Joshua E., Muszynski, Irvin L., Medication access and continuity: The experiences of dual-eligible psychiatric patients during the first 4 months of the Medicare prescription drug benefit. *Am J Psychiatry* 164:5, May 2007, pp. 789-796.