

“A medication that works well for one person with schizophrenia often doesn’t work well for another. Genetic variations are thought to play a key role in this difference in response. While patients search for the right medications, their illnesses may worsen.” The National Institute of Mental Health, Jan 2008¹

Introduction

The Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD) published policy recommendations on prescribing antipsychotic medications for schizophrenia in May 2008 (available on the Web at www.nasmhpd.org).

The Medical Directors Council’s recommendations may influence discussions and actions on medication access in your state. While the Council’s recommendations are thoughtful, they may be used by states to adopt restrictive preferred drug lists. We have developed a summary of the recommendations and talking points to assist you with addressing these policies.

Summary of the Medical Directors Council’s Statement on Antipsychotic Prescribing

The Medical Directors Council begins with a statement of principles that NAMI strongly supports. The principles say that medication treatment should be individualized to promote recovery. Medication treatment should also be effective, safe, and well tolerated, and should consider personal preferences and vulnerabilities. The final principle notes that cost considerations should only guide medication choices once all the other principles are met.

Table 1	
Medical Directors Council’s Principles of Antipsychotic Access, Efficient Utilization, and Prescribing	
1.	Treatment with antipsychotic medication, like any other treatment, should be individualized in order to optimally promote recovery.
2.	Treatment with antipsychotic medication should be as effective, safe, and well tolerated as possible.
3.	Treatment with antipsychotic medication should consider personal preference and vulnerabilities.
4.	Treatment with antipsychotic medication should provide value in terms of improved quality of life to the consumer.
5.	Treatment choices should be informed by the best current evidence and must evolve in response to new information.
6.	Cost considerations should guide antipsychotic medication selection once the preceding principles are met.

Next, the Medical Directors Council talks about two approaches to utilization of medications in drug benefit programs: an open formulary and a preferred drug list (PDL). The report states that an open formulary is clinically desired because it allows doctors to prescribe without restricting clinical decisions and imposing administrative burdens.

However, the statement also says that a PDL may provide adequate access to antipsychotics if it ensures open access to a range of medications with clinical differences and provides access to all other medications “through a responsive, user friendly, and timely process.”

The Council identifies key conditions and protections that must accompany a PDL: Consumers should easily receive any medication on which they are stable or have done well previously, often known as “grandfathering.”



Summary of the NASMHPD Medical Directors Council Statement on Antipsychotic Prescribing



When a non-formulary medication is considered clinically appropriate, prior authorization should be flexible and simple. And, patients should not be forced to switch medications because of changes in formulary, prior authorization, or payer.

The recommendations suggest that a PDL should provide open access to a choice of antipsychotic medications that have substantial clinical differences. The statement adds that a PDL should, at a minimum, include at least one antipsychotic in each of seven classes:

1. Relatively weight-neutral atypical antipsychotic medications;
2. High-potency atypicals;
3. Relatively sedating atypicals;
4. Clozapine;
5. Medium-potency typical antipsychotic medications;
6. High-potency typicals with long-acting formulations; and
7. Low potency typicals.

The Council states that its recommendations do not support three policies: step therapy requiring the trial of a typical antipsychotic before having access to an atypical; having only a single atypical as an open access (PDL) medication; and requiring a trial on one of the seven categories of antipsychotics before having access to the other six.

The report also recommends promoting best prescribing practices and encouraging treatment adherence through shared decision-making, recovery-oriented approaches, community case management and education of the consumer and family. The Council notes that improving prescribing practices should be the major focus of any program to manage medications and that improving these practices may lead to savings that can be used to meet other treatment needs.

Last, the Council highlights the need for clinical trials and dissemination of results and urges funding of ongoing research into the appropriate use of medications. The Council then summarizes research about antipsychotic effectiveness and prescribing and acknowledges that “there is no best medication or best dose for all patients; the choice of an antipsychotic medication and its dose, and subsequent decisions about changes in treatment require careful initial consideration and ongoing, shared decision-making between the patient and clinician.”

Implications

The Medical Directors Council statement on antipsychotic prescribing raises many policy issues. For example, states may pursue a preferred drug list that includes a minimal number of antipsychotics (one in each of seven classes). In such a PDL, some newer, atypical antipsychotics would be excluded (See Table 2). This means that consumers would have to go through prior authorization before they could get a medication that is not on the PDL.

Although the Medical Directors Council expressly calls for flexible and simple prior authorization procedures, experience tells us that these procedures are often neither flexible or simple and too often result in consumers going without the medications they need.

Several statements in the Council’s report have positive policy implications. For example, the Council recommends “grandfathering” consumers on medications that work or have worked for them. Several recommendations emphasize consumer protections that minimize the risk of relapse and ensure continuity of care.

In each state, the implications of the Medical Director Council’s statement will depend on current policies and the nature of any proposed policy changes.