Prime THERAPEUTICS™

New Hampshire Medicaid Fee-for-Service Program Antipsychotic Polypharmacy Criteria

Approval Date: May 12, 2026

Psychotropic Therapeutic Classes

Oral and injectable antipsychotic agents

Antipsychotic Polypharmacy POS response

If there are more than four antipsychotic medications prescribed within a 60 day look back period, the incoming claim will deny with message "Prior authorization required – antipsychotic polypharmacy noted with 4 or more agents. Provider to call 866-675-7755."

Criteria for Approval

1. Documented evidence that patient is receiving or has received psychiatry consultation; **AND**
2. Patient has a diagnosis in accordance with current Diagnostic and Statistical Manual of Mental Disorders (DSM); **AND**
3. Provider has provided a treatment plan and/or provided a titration plan and a monitoring schedule.

Criteria for Denial

Prior approval will be denied if the approval criteria are not met.

Length of Approval: 12 months

References

Available upon request.

Revision History

Reviewed by	Reason for Review	Date Approved
DUR Board	New	04/21/2026
Commissioner Designee	Approved	05/14/2026

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