

Effective Date:05/01/2025
Reviewed: 02/2025
Scope: Medicaid

Cobenfy (xanomeline and trospium chloride)

POLICY

I. CRITERIA FOR APPROVAL

An authorization of 12 months may be granted when all the following criteria are met:

- A. The member is 18 years of age or older
- B. The member is being treated for schizophrenia; AND
- C. The member has had a recent acute exacerbation or relapse of psychotic symptoms, with onset in the previous 2 months.
- D. The member has experienced a failure, contraindication, or intolerance to at least three formulary atypical antipsychotics (i.e., aripiprazole, olanzapine, quetiapine IR or ER, risperidone, or ziprasidone)
- E. Member does not have any contraindications/risks that would preclude use of Cobenfy (i.e., urinary retention, moderate to severe hepatic impairment, gastric retention, untreated narrow-angle glaucoma, active biliary disease)

II. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for all members who have documentation of a positive clinical response without contraindications/risks that would preclude use of Cobenfy.

III. QUANTITY LIMIT

- Cobenfy 50 mg/20 mg, 100 mg/20 mg and 125 mg/30 mg : 60 capsules per 30 days
- Cobenfy Starter Pack: 56 capsules per 28 days

IV. REFERENCES

1. Cobenfy [prescribing information]. Karuna Therapeutics, Inc. Princeton, NJ. December 2024.