Clinical Policy: Antidepressant Agents

Reference Number:OH.PHAR.PPA.36
Effective date: 01.01.2020
Last Review Date:
Line of Business: Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

ANTIDEPRESSANTS: SELECTIVE SEROTONIN REUPTAKE INHIBITOR (SSRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
CITALOPRAM solution (generic of Celexa®) CITALOPRAM tablets (generic of Celexa®) ESCITALOPRAM (generic of Lexapro®) FLUOXETINE HCL capsules, tablets (generic of Prozac®) FLUOXETINE HCL solution (generic of Prozac®) FLUVOXAMINE MALEATE (generic of Luvox®) PAROXETINE HCL (generic of Paxil®) SERTRALINE (generic of Zoloft®) SERTRALINE oral concentrate (generic of Zoloft®)	BRISDELLE® (paroxetine mesylate) FLUOXETINE ER (generic of Prozac Weekly®) FLUVOXAMINE ER (generic of Luvox CR®) PAROXETINE ER (generic of Paxil CR®) PEXEVA® (paroxetine mesylate)

ANTIDEPRESSANTS: SEROTONIN-NOREPINEPHRINE REUPTAKE INHIBITORS (SNRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
DULOXETINE 20mg, 30mg, 60mg (generic of Cymbalta®) VENLAFAXINE (generic of Effexor®) VENLAFAXINE ER capsule (generic of Effexor XR®)	DESVENLAFAXINE ER (generic of Khedezla ER®) DESVENLAFAXINE ER tablet DESVENLAFAXINE FUMARATE DULOXETINE 40mg (generic of Irenka®) FETZIMA® (levomilnacipran) PRISTIQ® (desvenlafaxine) VENLAFAXINE ER tablet

ANTIDEPRESSANTS: NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS (NDRI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
BUPROPION HCL (generic of Wellbutrin®) BUPROPION SR (generic of Wellbutrin SR®) BUPROPION XL (generic of Wellbutrin XL®)	APLENZIN™ (bupropion) FORFIVO XL® (bupropion)

ANTIDEPRESSANTS: ALPHA-2 RECEPTOR ANTAGONISTS*

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
MIRTAZAPINE (generic of Remeron®) MIRTAZAPINE rapid dissolve (generic of Remeron® Sol-Tab)	

ANTIDEPRESSANTS: MONOAMINE OXIDASE INHIBITORS (MAOI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
TRANYLCYPROMINE (generic of Parnate®)	EMSAM® patches (selegiline) MARPLAN® (isocarboxazid) PHENELZINE (generic of NARDIL®)

ANTIDEPRESSANTS: Serotonin-2 Antagonist/Reuptake Inhibitors (SARI)*

NO PA REQUIRED "PREFERRED"	PA REQUIRED "NON-PREFERRED"
TRAZODONE 50mg, 100mg, 150mg NEFAZODONE	OLEPTRO ER® (trazodone) TRAZODONE 300mg

ANTIDEPRESSANTS: SSRI - SEROTONIN PARTIAL AGONIST*

NO PA REQUIRED "PREFERRED GENERIC"	PA REQUIRED "NON-PREFERRED"
	TRINTELLIX® (vortioxetine) VIIBRYD® (vilazodone)

FDA Approved Indication(s)

- Refer to Clinical Pharmacology or other appropriate clinical resource for FDA approved indications

Policy/Criteria

Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that the medications listed in the above tables are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Prescribed indication is FDA-approved or supported by standard pharmacopeias (must meet all)**:**

1. The requested medication's corresponding generic (if covered by the state) has been attempted and failed or is contraindicated.
2. Member has tried and failed no less than two preferred medications, in the same therapeutic class, not requiring prior authorization for a 30 day trial of each unless one of the following:

a. Allergy to preferred medications
b. Contraindication to or drug interaction with preferred medications
c. History of unacceptable/toxic side effects to preferred medications
d. For orally disintegrating tablet dosage forms, the patient is unable or unwilling to swallow the standard tablet/capsule dosage form.

3. If the medication is Trintellix or Viibryd member has tried and failed one SSRI and one SNRI not requiring prior authorization for a 30 day trial of each unless one of the following:
    a. Allergy to preferred medications
    b. Contraindication to or drug interaction with preferred medications
    c. History of unacceptable/toxic side effects to preferred medications
    d. For orally disintegrating tablet dosage forms, the patient is unable or unwilling to swallow the standard tablet/capsule dosage form.
4. If the medication is Emsam patches, Marplan or phenelzine (Nardil) member has tried and failed tranylcypromine (Parnate) and one other preferred medication not requiring prior authorization for a 30 day trial of each unless one of the following:
    a. Allergy to preferred medications
    b. Contraindication to or drug interaction with preferred medications
    c. History of unacceptable/toxic side effects to preferred medications
    d. For orally disintegrating tablet dosage forms, the patient is unable or unwilling to swallow the standard tablet/capsule dosage form.

Approval duration: 12 months

II. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policy – CP.PMN.53 for Medicaid or evidence of coverage documents.

III. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

SSRI: selective serotonin reuptake inhibitor
SNRI: serotonin norepinephrine reuptake inhibitor
MAOI: monoamine oxidase inhibitor
FDA: Food and Drug Administration

Appendix B: Therapeutic Alternatives

• Dosing varies by drug product. See FDA approved dosing and administration.

Appendix C: Contraindications/Boxed Warnings

• Refer to Clinical Pharmacology or other appropriate clinical resource for contraindications or black box warnings

IV. Dosage and Administration

A. Varies by drug product. See FDA approved dosing and administration.

V. Product Availability

A. Varies by drug product. Refer to Clinical Pharmacology or other appropriate clinical resource for product availability.

VI. References

Refer to package insert

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	11.2019	

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.