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## DRUG POLICY

# Antidepressant Drug Policy

### NOTICE

This policy contains information which is clinical in nature. The policy is not medical advice. The information in this policy is used by Wellmark to make determinations whether medical treatment is covered under the terms of a Wellmark member's health benefit plan. Physicians and other health care providers are responsible for medical advice and treatment. If you have specific health care needs, you should consult an appropriate health care professional. If you would like to request an accessible version of this document, please contact customer service at 800-524-9242.

### BENEFIT APPLICATION

Benefit determinations are based on the applicable contract language in effect at the time the services were rendered. Exclusions, limitations or exceptions may apply. Benefits may vary based on contract, and individual member benefits must be verified. Wellmark determines medical necessity only if the benefit exists and no contract exclusions are applicable. This policy may not apply to FEP. Benefits are determined by the Federal Employee Program.

### DESCRIPTION

The intent of the Antidepressant Drug Policy is to ensure appropriate selection of patients for treatment according to product labeling and/or clinical studies and/or guidelines, and to encourage use of more cost-effective generic immediate release agents prior to the use of a generic or brand name delayed release agent, a brand name immediate release agent, or a more costly generic.

### POLICY

#### Criteria for Initial Approval

- I. Khedezla (brand and generic) and Desvenlafaxine fumarate ER may be considered **medically necessary** for the treatment of depression when all of the following criteria are met:
  - Patient has a diagnosis of major depressive disorder (MDD)
  - Patient must have had a therapeutic failure to ALL of the following unless the patient is currently receiving a positive therapeutic outcome on the requested medications through health insurance (excludes obtainment as samples or via manufacturer's patient assistance programs):
    - i. Extended-release venlafaxine at a maximally tolerated therapeutic dose for a minimum duration of 2 months
    - ii. One generic selective serotonin reuptake inhibitor (SSRI) at a maximally tolerated therapeutic dose for a minimum duration of 2 months OR the patient has experienced the same intolerable side effect with more than one SSRI trial, deemed a class effect of SSRI medication
    - iii. One alternative treatment strategy (bupropion, mirtazapine, trazodone, lithium, or another augmentation agent) at a maximally tolerated therapeutic dose for a minimum duration of 2 months

- Quantity request must not exceed 30 tablets per month

**Approval will be for 24 monthsa**

II. Viibryd (brand and generic) and Fetzima may be considered **medically necessary** for the treatment of depression when all of the following criteria are met:

- Patient has a diagnosis of major depressive disorder (MDD)
- Patient must have had a therapeutic failure to ALL of the following unless the patient is currently receiving a positive therapeutic outcome on the requested medications through health insurance (excludes obtainment as samples or via manufacturer's patient assistance programs):
  - i. One generic selective serotonin reuptake inhibitors (SSRI) at maximally tolerated therapeutic dose for a minimum duration of 2 months OR the patient has experienced the same intolerable side effect with more than one SSRI trial, deemed a class effect of SSRI medication
  - ii. One generic serotonin norepinephrine reuptake inhibitor (SNRI) at a maximally tolerated therapeutic dose for a minimum duration of 2 months OR the patient has experienced an intolerable side effect with more than one SNRI trial
  - iii. One alternative treatment strategy (bupropion, mirtazapine, trazodone, lithium, or another augmentation agent) at a maximally tolerated therapeutic dose for a minimum duration of 2 months

**Approval will be for 24 months**

III. Pexeva may be considered **medically necessary** when all of the following criteria are met:

- Patient must have at least one of the following diagnoses:
  - i. Major Depressive Disorder (MDD)
  - ii. Generalized Anxiety Disorder (GAD)
  - iii. Obsessive Compulsive Disorder (OCD)
  - iv. Panic Disorder
- Patient must have had a therapeutic failure to ALL of the following unless the patient is currently receiving a positive therapeutic outcome on Pexeva through health insurance (excludes obtainment as samples or via manufacturer's patient assistance programs):
  - i. Generic paroxetine for at least 2 months at a maximally tolerated therapeutic dose
  - ii. One selective serotonin reuptake inhibitor (SSRI), other than generic paroxetine, for at least 2 months at a maximally tolerated therapeutic dose
  - iii. One generic serotonin norepinephrine reuptake inhibitor (SNRI) for at least 2 months at a maximally tolerated therapeutic dose OR the patient has experienced an intolerable side effect with more than one SNRI trial.

**Approval will be for 24 months**

IV. Luvox CR and generic equivalent may be considered **medically necessary** for the treatment of obsessive-compulsive disorder (OCD) when the following criteria is met:

- Member must have tried and failed TWO generic selective serotonin reuptake inhibitors (SSRI), one of which was the immediate release Luvox (fluvoxamine) at maximally tolerated therapeutic doses for a minimum duration of 2 months each unless the patient is currently receiving a positive therapeutic outcome on the requested medications through health insurance (excludes obtainment as samples or via manufacturer's patient assistance programs):

**Approval will be for 24 months**

- V. Trintellix may be considered **medically necessary** for the treatment of depression when all of the following criteria are met:
- Patient has a diagnosis of major depressive disorder (MDD)
  - Patient must have had a therapeutic failure to ALL of the following unless the patient is currently receiving a positive therapeutic outcome on Trintellix through health insurance (excludes obtainment as samples or via manufacturer's patient assistance programs):
    - i. Two generic selective serotonin reuptake inhibitors (SSRI) at maximally tolerated therapeutic doses for a minimum duration of 2 months each OR the patient has experienced the same intolerable side effect with more than one SSRI trial, deemed a class effect of SSRI medication..
    - ii. One generic serotonin norepinephrine reuptake inhibitor (SNRI) at a maximally tolerated therapeutic dose for a minimum duration of 2 months OR the patient has experienced an intolerable side effect with more than one SNRI trial.
    - iii. One alternative treatment strategy (bupropion, mirtazapine, trazodone, lithium, or another augmentation agent) at a maximally tolerated therapeutic dose for a minimum duration of 2 months.

**Approval will be for 24 months**

- VI. Khedezla (brand and generic), Desvenlafaxine fumarate ER, Viibryd, Fetzima, Pexeva, Luvox CR, and Trintellix are considered **not medically necessary** for patients who are started on therapy using "samples" (i.e. not a medication dispensed from the pharmacy or initiated during inpatient mental health hospitalization) without meeting the criteria set forth above.
- VII. Khedezla (brand and generic), Desvenlafaxine fumarate ER, Viibryd, Fetzima, Pexeva, Luvox CR, and Trintellix are considered **not medically necessary** for patients who do not meet the criteria set forth above.

Quantity Limits Apply

- Desvenlafaxine ER 30 tablets/30 days
- Desvenlafaxine Fumarate ER 30 tablets/30days
- Fetzima 30 capsules/30days
- Fetzima Pack 2 packs per 365 days
- Khedezla (brand and generic) 30 tablets/30 days
- Trintellix 30 tablets/30 days
- Viibryd (brand and generic) 30 tablets/30 days
- Viibryd Starter Pack 2 packs per 365 days

Appendix

**FDA Maximum Recommended Dosages**

Brand Name	Generic Name	Maximum Recommended Dosage
<b>Selective serotonin reuptake inhibitors (SSRIs)</b>		
Celexa	citalopram	20* to 40 mg per day
Lexapro	escitalopram	20 mg per day
Prozac/Prozac Weekly	fluoxetine	80-90 mg per day
Luvox	fluvoxamine	300 mg per day

Brand Name	Generic Name	Maximum Recommended Dosage
Paxil/Paxil CR	paroxetine	50 to 75 mg per day
Zoloft	sertraline	200 mg per day
<b>Serotonin-norepinephrine reuptake inhibitors</b>		
Cymbalta	duloxetine	60 to 120** mg per day
Effexor/Effexor XR	venlafaxine	225 mg per day
<b>Alternative treatment strategies</b>		
Wellbutrin/Wellbutrin XL/Wellbutrin SR/ Budeprion/Buproban	Bupropion	450 mg per day
Remeron	mirtazapine	45 mg per day
Oleptro	trazodone	400 mg per day

\*Maximum recommended dose for patients with hepatic impairment, patients who are older than 60 years of age, patients who are CYP2C19 poor metabolizers, or patient who are taking concomitant cimetidine or another CYP2C19 inhibitor

\*\*Doses > 60 mg did not confer additional benefit in clinical trials

## PROCEDURES AND BILLING CODES

**To report provider services, use appropriate CPT\* codes, Alpha Numeric (HCPCS level 2) codes, Revenue codes, and/or ICD diagnostic codes.**

- Code(s), if applicable.

## REFERENCES

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- Trintellix [*prescribing information*]. Deerfield, IL: Takeda Pharmaceuticals America, Inc., January 2021.
- Pexeva [*prescribing information*]. Miami, FL: Noven Therapeutics, LLC., January 2021.
- Luvox CR [*prescribing information*]. Palo Alto, CA: Jazz Pharmaceuticals, Inc., July 2014.
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- Khedezla [*prescribing information*] Spring Valley, NY: Par Pharmaceutical Cos., Inc., September 2013
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## POLICY HISTORY

**Policy #:** 05.01.62

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