Antidepressant Drug Policy

**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):
  - Extended-release venlafaxine at a maximally tolerated therapeutic dose for a minimum duration of 2 months
  - 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
  - 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 lifetime

II. Viibryd 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 lifetime

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 lifetime

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 lifetime

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 lifetime

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/30 days, Fetzima 30 capsules/30 days, Khedezla 30 tablets/30 days

**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**


**POLICY HISTORY**

Policy #: 05.01.62  
Policy Creation: May 2009  
Revised: July 2018  
Reviewed: July 2019  
Current Effective Date: September 20, 2018