Antidepressant Medications
Desvenlafaxine (Pristiq); Duloxetine (Cymbalta), Fluoxetine Tablets (Sarafem); Fluvoxamine ER (Luvox CR); Imipramine pamoate (Tofranil-PM); Levomilnacipran (Fetzima); Paroxetine (Brisdelle); Paroxetine ER (Paxil CR); Protriptyline (Vivactil); Selegiline Transdermal (Emsam); Trimipramine (Surmontil); Venlafaxine extended-release; Vilazodone (Viibryd); Vortioxetine (Brintellix)

Effective: 10/1/15

Clinical documentation and prior authorization required ✓ Type of review – case management
Not covered Type of review – clinical review Fax: 617-673-0988 ✓
Pharmacy (RX) or medical (MED) benefit RX Department to review RxUM

OVERVIEW
FDA-APPROVED INDICATIONS

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Major Depressive Disorder</th>
<th>Depression</th>
<th>Generalized Anxiety Disorder</th>
<th>Social Anxiety Disorder</th>
<th>Obsessive-Compulsive Disorder</th>
<th>Panic Disorder</th>
<th>Fibromyalgia</th>
<th>Diabetic Peripheral Neuropathic Pain</th>
<th>Chronic Musculoskeletal Pain</th>
<th>Premenstrual Dysphoric Disorder</th>
<th>Vasomotor Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Desvenlafaxine</td>
<td>Pristiq</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duloxetine</td>
<td>Cymbalta</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoxetine Tablets</td>
<td>Sarafem</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluvoxamine</td>
<td>Luvox CR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Imipramine Pamoate</td>
<td>Tofranil-PM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levomilnacipran</td>
<td>Fetzima</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paroxetine 7.5 mg caps</td>
<td>Brisdelle</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paroxetine extended-release tablets</td>
<td>Paxil CR</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Protriptyline</td>
<td>Vivactil</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Selegiline Transdermal</td>
<td>Emsam Patch</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trimipramine</td>
<td>Surmontil</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venlafaxine extended-release tablets</td>
<td>Venlafaxine ER Tabs</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vilazodone</td>
<td>Viibryd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vortioxetine</td>
<td>Brintellix</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PHARMACY COVERAGE GUIDELINES
Tufts Health Plan – Network Health may authorize coverage of a non-preferred antidepressant agent for members when all of the following criteria for a particular regimen are met and limitations do not apply:

For members less than 6 years of age,
- The member has been evaluated by a specialist AND
- The request is for an FDA approved diagnosis or for an off-label use supported by recognized medical compendia.
For members at least 6 years of age,
- The member is stabilized on the requested medication for a duration of at least 2 months OR
- The member recently started on the requested medication in an acute care setting, residential setting, or partial hospital setting OR
- One of the following drug-specific criteria:

**Desvenlafaxine**
- The member has tried and failed therapy with venlafaxine ER capsules or tablets.

**Duloxetine**
- For the diagnosis of depression or anxiety;
  - The member has tried and failed therapy with a selective serotonin reuptake inhibitor (SSRI), a tricyclic antidepressant, a monoamine oxidase inhibitor or another serotonin-norepinephrine reuptake inhibitor such as venlafaxine or desvenlafaxine. OR
  - The member has depression and anxiety in combination with pain symptoms that cause clinically significant distress or impairment.
- For the diagnosis of fibromyalgia,
  - The member has tried and failed therapy with at least two of the following alternative agents: a tricyclic antidepressant (TCA), SSRI, milnacipran, gabapentin, pregabalin, or another serotonin-norepinephrine reuptake inhibitor (SNRI; e.g., venlafaxine, desvenlafaxine).
- For the diagnosis of neuropathic pain or a condition associated with neuropathic pain,
  - The member has tried and failed therapy with at least two alternative agents for neuropathic pain, one being either gabapentin or pregabalin, and another being an antidepressant agent (TCA, venlafaxine, desvenlafaxine) or another anticonvulsant agent (e.g., carbamazepine or lamotrigine).
- For the diagnosis of osteoarthritic pain,
  - The member has tried and failed therapy with at least two alternative analgesic therapies (e.g., acetaminophen, oral or topical non-steroidal agents (NSAIDs), or glucocorticoid injections).
- For the diagnosis of musculoskeletal pain,
  - The member has tried and failed therapy with at least three alternative therapies from at least two different therapeutic classes (e.g., analgesics, antidepressants, anticonvulsants, or skeletal muscle relaxants).

**Fluoxetine Tablets (Sarafem)**
- The member has tried and failed therapy with two alternative agents for premenstrual dysphoric disorder.

**Fluvoxamine extended-release capsules**
- The member has tried and failed therapy, or has a contraindication to therapy, with at least two alternative SSRIs.
- Therapy with immediate-release fluvoxamine has not provided a sufficient response.

**Levomilnacipran (Fetzima)**
- The member has tried and failed therapy with at least two alternative antidepressant agents, one of which must be an SNRI (i.e., venlafaxine, desvenlafaxine, duloxetine).

**Paroxetine 7.5 mg capsules (Brisdelle)**
- The member has tried and failed therapy with two alternative agents for vasomotor symptoms of menopause.

**Paroxetine extended-release tablets**
- The member tried and failed therapy with, or has a contraindication to therapy with at least two alternative SSRIs.
- Therapy with immediate-release paroxetine has not provided a sufficient response.

**Selegiline Transdermal (Emsam)**
- The member is diagnosed with major depression.
- The member has been evaluated by a psychiatric prescriber.
- Rationale with one of the following criterion:
The member has had a favorable response to an oral MAO-I inhibitor and is unable to continue treatment with an oral MAO-I agent.

The member tried and failed treatment with three alternative agents; i.e. at least one alternative agent from at least three alternative therapeutic classes (e.g., alpha-2 antagonists, Norepinephrine Dopamine Receptor Inhibitors (NDRIs), SSRIs, SNRIs, TCAs).

**Imipramine Pamoate or Protriptyline**
- The member has tried and failed therapy with one alternative TCA.

**Trimipramine (Surmontil)**
- The member has tried and failed therapy with at least two alternative TCAs.

**Vilazodone (Viibryd)**
- The member has tried and failed therapy with at least two alternative SSRIs.

**Vortioxetine (Brintellix)**
- The member has tried and failed therapy with two alternative antidepressants, one of which must be an SSRI.

**LIMITATIONS**
- Requests for brand-name products, which have AB-rated generics, will be reviewed according to Brand Name criteria.
- The length of approval will be for two years; subsequent approval will require the member has had an office visit and has been re-assessed for this condition within the past year, and continued therapy with this medication is medically necessary.
- Coverage is limited to the following:
  - Duloxetine 20 mg and 60 mg: two capsules per day.
  - Duloxetine 30 mg: one capsule per day.
  - Fluvoxamine ER: one capsule per day.
  - Levomilnacipran: one tablet per day.
  - Paroxetine CR: one tablet per day.
  - Selegiline Transdermal: one patch per day.
  - Vilazodone: one tablet per day.
  - Vortioxetine: one tablet per day.
- Quantities that exceed the quantity limit will be reviewed according to the Drugs w/ Quantity Limitations criteria.

**CODES**
None

**REFERENCES**
1. Paxil CR (paroxetine) [prescribing information]. Research Triangle Park, NC; GlaxoSmithKline; June 2014.
2. Brisdelle (paroxetine) [prescribing information]. Miami, FL: Noven Therapeutics; Dec 2014.
4. Fetzima (levomilnacipran) [prescribing information]. St. Louis, MO: Forest Pharmaceuticals Inc; July 2014.
5. Cymbalta (duloxetine) [prescribing information]. Indianapolis, IN: Eli Lilly and Company; November 2014.
6. Vivactil (protriptyline) [prescribing information]. Horsham, PA: Teva; May 2014.


21. Viibryd (vilazodone) [prescribing information]. St. Louis, MO: Forest Pharmaceuticals; December 2012.

### APPROVAL HISTORY

- 1/13/15: Reviewed by the Pharmacy and Therapeutics Committee; Individual drug criteria consolidated into Antidepressant Agents Medical Necessity Guidelines.
- 6/9/15: Reviewed by the Pharmacy and Therapeutics Committee; incorporated criteria specific for Together members less than 6 year of age; duration approval modified to two years.

### BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION

Pharmacy Medication Request Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with the applicable Member Handbook and in coordination with the member’s physician(s). Pharmacy Medication Request Guidelines are developed for selected therapeutic classes or drugs found to be safe but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medication Request Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medication Request Guidelines apply to fully insured Tufts Health Together offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the Preferred Drug List (formulary) in the pharmacy section of our website to determine if the drug requires you to get prior authorization.

For Tufts Health Direct (individual and small-group plan), please refer to the Tufts Health Direct Pharmacy Medical Necessity Guidelines.

For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to the Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines, when applicable, and adherence to plan policies and procedures and claims editing logic.