Mass General Brigham
Health Plan

Antidepressants
Effective 12/04/2023

Plan	☒ MassHealth UPPL ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☒ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☒ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	Zulresso is available through medical benefit only. Spravato is available through both pharmacy and medical benefits.		

Overview

No PA	Require PA
Combination agents	
	amitriptyline/chlordiazepoxide ††
	amitriptyline/perphenazine ‡‡
	Symbyax® (olanzapine/fluoxetine) *
Norepinephrine-dopamine reuptake inhibitors (NDRIs)	
	Aplenzin® (bupropion hydrobromide extended-release) > 1 unit/day
bupropion hydrochloride	Forfivo XL® (bupropion hydrochloride extended-release 450 mg tablet¶ BP
Wellbutrin® SR # (bupropion hydrochloride sustained-release)	
	Wellbutrin® XL # (bupropion hydrochloride extended-release 150 mg, 300 mg tablet) * > 1 unit/day
Monoamine oxidase inhibitors (MAOIs)	
Nardil® # (phenelzine)	Emsam® (selegiline transdermal patch)
tranylcypromine	Marplan® (isocarboxazid)
Noradrenergic and specific serotonergic antidepressant (NaSSA)	
Remeron® # (mirtazapine)	Remeron® Sol Tab (mirtazapine orally disintegrating tablet) *
Serotonin modulators	

nefazodone	trazodone 300 mg tablet
trazodone 50 mg, 100 mg, 150 mg	Trintellix® (vortioxetine)
	Viibryd® (vilazodone)*
Serotonin/norepinephrine reuptake inhibitors (SNRIs)	
Cymbalta® # (duloxetine 20 mg, 30 mg, 60 mg)	duloxetine 40 mg
	Drizalma® (duloxetine sprinkle capsule)
Effexor® XR # (venlafaxine extended-release capsule)	desvenlafaxine extended-release ‡
	Fetzima® (levomilnacipran)
	Pristiq® # (desvenlafaxine succinate extended release)*[BP] > 1 unit/day
venlafaxine	venlafaxine besylate extended-release tablet
	venlafaxine hydrochloride extended-release tablet
Selective serotonin reuptake inhibitors (SSRIs)	
Celexa® # (citalopram solution, tablet)	citalopram capsule
fluoxetine 10 mg, 20 mg tablet for premenstrual dysphoric disorder	fluoxetine 60 mg tablet †
	fluoxetine 90 mg delayed-release capsule
fluvoxamine immediate-release	fluvoxamine extended-release
Lexapro® # (escitalopram)	
Paxil® # (paroxetine hydrochloride)	Paxil® CR (paroxetine controlled-release) *
Prozac® # (fluoxetine 10 mg, 20 mg, 40 mg capsule, solution)	Pexeva® (paroxetine mesylate)
Zoloft® # (sertraline oral concentrate, tablet)	sertraline capsule
Tricyclic antidepressants (TCAs)	
amitriptyline tablet	Anafranil® (clomipramine) *
amoxapine	imipramine pamoate
doxepin capsule, oral concentrate	
imipramine hydrochloride	Norpramin® (desipramine) *
Pamelor® # (nortriptyline)	protriptyline
	trimipramine
N-methyl-D-aspartate (NMDA) receptor antagonists	
	Auvelity® (dextromethorphan/bupropion) Spravato® (esketamine)
Gamma-aminobutyric acid (GABA)-A receptor positive modulator	
	Zulresso® (brexanolone) [MB]

This is a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA “A"-rated generic equivalent.

MB This agent is available through the health care professional who administers the drug.

* A-rated generic available. Both brand and A-rated generic require PA.

BP Brand Preferred over generic equivalents. In general, requires a trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

† Fluoxetine 60 mg tablet is a branded agent without a proprietary name.

‡ Desvenlafaxine extended-release products are non AB-rated formulations to Pristiq® (desvenlafaxine succinate extended-release).

§ Use of antidepressants in members less than 18 years of age is discussed in the Pediatric Behavioral Health Medication Initiative guideline.

¶ Authorized generic. Requires PA.

†† Please review using criteria in the Benzodiazepine and other Antianxiety Agents guideline.

‡‡ Please review using criteria in the Antipsychotics guideline.

Approvable Diagnoses:

- Anxiety disorder
- Bipolar disorder
- Depressive disorder
- Obsessive-compulsive disorder
- Panic disorder
- Post-traumatic stress disorder
- Other psychiatric or neurologic condition requiring treatment with an antidepressant (i.e., psychotic disorder, neuropathic pain)

The **Pediatric Behavioral Health Medication Initiative** may apply to members <18 years of age due to polypharmacy, age, and/or drug restrictions. As indicated within this guideline, please refer to the **Pediatric Behavioral Health Medication Initiative** guideline to assess appropriateness of therapy.

Coverage Guidelines

Authorization may be reviewed on a case by case basis for members who are new to the plan currently receiving treatment with requested medication excluding when the product is obtained as samples or via manufacturer's patient assistance programs.

OR

Authorization will be granted when all the following criteria has been met:

Anafranil® (clomipramine)

ALL of the following:

1. **ONE** of the approvable diagnoses (listed above)
2. Paid claims or physician attestation of inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to **TWO** or contraindication to **ALL** SSRIs antidepressants

Forfivo XL® (bupropion hydrochloride extended-release 450 mg tablet)[BP]

ALL of the following:

1. **ONE** of the approvable diagnoses (listed above)
2. Member is ≥18 years of age
3. Medical records documenting an inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to bupropion SR or XL

desvenlafaxine extended-release

ALL of the following:

1. **ONE** of the approvable diagnoses (listed above)
2. Member is ≥18 years of age
3. Medical records documenting an inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to desvenlafaxine succinate extended-release (brand or A-rated generic for Pristiq®)

Drizalma® (duloxetine sprinkle capsule)

ALL of the following:

1. **ONE** of the approvable diagnoses (listed above)
2. Clinical rationale for the requested formulation instead of solid oral formulation (e.g., swallowing disorder, dysphagia)

Emsam® (selegiline transdermal system)
ONE of the following:

1. Diagnosis of major depressive disorder
    a. Member is >18 years of age
    b. **ONE** of the following:
        i. Medical necessity for the use of a transdermal formulation
        ii. Paid claims or physician attestation of inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to **ONE** SSRI and **ONE** non-SSRI
        iii. Contraindication to all SSRI antidepressants and non-SSRI antidepressants
    c. If the request is for a quantity > 1 patch and/or 12 mg daily prescriber must provide documentation of appropriate clinical rationale for dosing higher than the FDA approved limits
2. Diagnosis of Parkinson's Disease (off-label)
    a. Member is > 18 years of age
    b. Medical necessity for use of a transdermal formulation
    c. Requested quantity is ≤ 9 mg/day*

Notes:

- Please see appendix for information regarding requests stating the member is unable to adhere to a tyramine-restricted diet.
- *Please see appendix for information regarding the use of Emsam® in the treatment of Parkinson's disease

Norpramin® (desipramine)
ONE of the following:

1. **ONE** of the approvable diagnoses (listed above)
    a. Member is ≥18 years of age
    b. Paid claims or physician attestation of inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to **ONE** or contraindication to **BOTH** of the following
        i. SSRI
        ii. SNRI
    c. Paid claims or physician attestation of inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to **ONE** TCA antidepressant available without prior authorization
2. Diagnosis of **ONE** of the following (off-label): Fibromyalgia, Diabetic neuropathy, Postherpetic neuralgia
    a. Paid claims or physician attestation of inadequate response (defined as ≥ 4 weeks of therapy) or adverse reaction to **ONE** other tricyclic antidepressant or contraindication to **ALL** other tricyclic antidepressants
    b. Appropriate dosing

citalopram capsule
duloxetine 40 mg
fluoxetine 60 mg tablet
fluoxetine 90 mg delayed-release capsule
fluvoxamine extended-release
imipramine pamoate
sertraline capsule
trazodone 300 mg tablet
venlafaxine besylate extended release tablet
venlafaxine hydrochloride extended-release tablet
ALL of the following:

1. **ONE** of the approvable diagnoses (listed above)
2. Appropriate dosing
3. Medical records documenting inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to the respective formulation of the agent requested that is available without prior authorization:
    a. citalopram capsule: citalopram tablets (three 10 mg tablets or one 10 mg and one 20 mg tablet)
    b. fluoxetine 60 mg tablet: fluoxetine (three 20 mg capsules or tablets)
    c. fluvoxamine extended-release: immediate-release fluvoxamine
    d. duloxetine 40 mg: duloxetine (two 20 mg capsules)
    e. fluoxetine 90 mg (weekly): fluoxetine daily (i.e., compliance issues where weekly administration allows supervised medication administration)
    f. imipramine pamoate: imipramine hydrochloride
    g. sertraline capsule: sertraline tablets (one 50 mg and one 100 mg tablet [150 mg capsule] or two 100 mg tablets [200 mg capsule])
    h. trazodone 300 mg tablet: trazodone immediate-release (two 150 mg tablets)
    i. venlafaxine besylate extended-release tablet, venlafaxine hydrochloride extended-release tablet: venlafaxine extended-release capsules

maprotiline
Marplan® (isocarboxazid)
protriptyline
trimipramine
ALL of the following:
1. **ONE** of the approvable diagnoses (listed above)
2. Member is ≥18 years of age
3. Paid claims or physician attestation of inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to **ONE** or contraindication to **BOTH** of the following
    a. SSRI
    b. SNRI
4. Paid claims or physician attestation of inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to **ONE** TCA antidepressant available without prior authorization

Paxil® CR (paroxetine controlled-release)
Pexeva® (paroxetine mesylate)
ALL of the following:
1. **ONE** of the approvable diagnoses (listed above)
2. Member is ≥18 years of age
3. Medical records documenting an inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to immediate-release paroxetine
4. For Pexeva® (paroxetine mesylate) requests, member must meet the above criteria and prescriber must provide medical records documenting and inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to paroxetine controlled-release formulation

Remeron® Sol Tab (mirtazapine orally disintegrating tablet)
ALL of the following:
1. **ONE** of the approvable diagnoses (listed above)
2. **ONE** of the following:
    a. Medical necessity for the ODT formulation

b. Medical records documenting an inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to mirtazapine tablet

Spravato® (esketamine)
ONE of the following:

1. Diagnosis of Treatment resistant depression (TRD)
    a. Member is ≥18 years of age
    b. Prescriber is a specialist (i.e., psychiatrist) or consult notes from a specialist are provided
    c. Medical records documenting an inadequate response (defined as at least four weeks of therapy) or adverse reaction to **ONE** SSRI and **ONE** other non-SSRI antidepressant
    d. Medical records documenting an inadequate response (defined as at least four weeks of therapy for antidepressants) or adverse reaction with **ONE** or contraindication to **ALL** of the following antidepressant augmentation strategies:
        i. Second-generation antipsychotic *(Aripiprazole, olanzapine, quetiapine extended-release, and Rexulti® [brexpiprazole])*
        ii. Lithium
        iii. A second antidepressant from a different class
        iv. Thyroid hormone
    e. Requested agent will be used in combination with an oral antidepressant
    f. Appropriate dosing
2. Diagnosis of Treatment of depressive symptoms in adults with MDD with acute suicidal ideation or behavior
    a. Member is ≥18 years of age
    b. Prescriber is a specialist (i.e., psychiatrist) or consult notes from a specialist are provided
    c. **ONE** of the following:
        i. Medical records documenting current acute suicidal ideation or behavior related to depressive symptoms of MDD
        ii. Member was stabilized on esketamine during a psychiatric hospitalization
    d. Requested agent will be used in combination with an oral antidepressant*
    e. Appropriate dosing

***** Requests that indicate that Spravato® will be used in combination with quetiapine can be approved if all other criteria are met

Symbyax® (fluoxetine/olanzapine)
ALL of the following:

1. Diagnosis of ONE of the following:
    a. Depressive episodes associated with bipolar disorder
    b. Treatment resistant depression
2. Medical necessity for the use of the combination product instead of the commercially available separate agents

Auvelity® (dextromethorphan/ bupropion)
Fetzima® (levomilnacipran)
Trintellix® (vortioxetine)
Viibryd® (vilazodone)
ALL of the following:

1. Diagnosis of depression
2. Member is ≥18 years of age

3. Paid claims or physician attestation of inadequate response (defined as at least 4 weeks of therapy) or adverse reaction to **ONE** SSRI and **ONE** other non-SSRI antidepressant or contraindication to **ALL** SSRI and non-SSRI antidepressants
4. **ONE** of the following*:
    a. For Trintellix, and vilazodone, requested quantity is ≤ 1 unit/day
    b. For Auvelity, requested quantity is ≤ 2 units/day

** Requests that exceed quantity limits due to a non-commercially available dose (i.e., Trintellix® 15 mg) should generally be approved if the dose requested is within FDA-approved dosing and unable to consolidate quantity further with available strengths.*

Zulresso® (brexanolone)[MB]
ALL of the following:
1. Diagnosis of postpartum depression
2. Member is ≥18 years of age
3. Prescriber is a specialist (e.g., obstetrician-gynecologist or psychiatrist) or consult notes from a specialist are provided
4. Member is ≤6 months postpartum at screening with onset of a major depressive episode no earlier than the third trimester and no later than 4 weeks after delivery
5. Member is not currently pregnant
6. Appropriate dosing (weight required)

Exceeding Quantity Limit of >1 unit/day
Aplenzin® (bupropion hydrobromide extended-release)
Fetzima® (levomilnacipran)
Pristiq® (desvenlafaxine succinate extended-release)[BP]
Wellbutrin® XL (bupropion hydrochloride extended-release 150 mg, 300 mg tablets)
ALL of the following:
1. Appropriate diagnosis
2. **ONE** of the following:
    a. Clinical rationale why the dose cannot be consolidated
    b. Clinical rationale why the member requires dosing at intervals exceeding what is recommended by the FDA (for example twice daily when FDA approved dosing is only once daily)

Antidepressant Polypharmacy (Members ≥ 18 years of age)
Overlap of ≥60 out of 90 day period of ≥2 SSRIs, SNRIs (excluding Fetzima®), serotonin modulators (excluding trazodone), or ≥60 out of 90 day overlap in prescriptions for any dosage form of SNRIs (excluding Fetzima®), SSRIs and serotonin modulators (excluding trazodone)
ALL of the following:
1. Individual drug PA criteria must be met first where applicable within established quantity limits for the individual drug
2. Psychiatric diagnosis including severe or treatment-resistant conditions
3. Clear treatment plan including names and doses of current antidepressants and corresponding diagnoses
4. Prescriber is a psychiatrist or consult notes from a psychiatrist are provided
5. **ONE** of the following:
    a. Cross-titration/taper of antidepressant therapy
    b. Paid claims or physician attestation of inadequate response or adverse reaction to **TWO** monotherapy trials as clinically appropriate

c. Member had recent psychiatric hospitalization and was discharged on the current regimen

Continuation of Therapy
Reauthorization by physician will infer a positive response to therapy.

Limitations

1. Initial approvals will be granted for the following:
    a. Zulresso: 1 month
    b. Spravato: 3 months (treatment resistant depression), 1 month (depressive symptoms in adults with MDD with acute suicidal ideation or behavior)
    c. All other requests: up to 12 months
2. Reauthorizations will be granted for 12 months
    a. Requests for recertification of Spravato® (esketamine) beyond 1 month of treatment for the indication of depressive symptoms in adults with MDD with acute suicidal ideation or behavior should meet criteria for TRD
    b. Reauthorizations of Zulresso will not be granted as retreatment has not been established.
3. **Requests for Brand Name when generic is preferred:** In addition to any prior authorization requirements that may be listed above, if an A-rated generic equivalent is available, such prior authorization requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the generic equivalent drug (history of allergic reaction to the inactive ingredients used in the manufacturing process of a certain drug is acceptable).
4. **Requests for generic when Brand Name is preferred:** There are some drugs for which the Plan has determined it will be cost effective to prefer the use of the Brand Name formulation. In this case, the generic equivalent formulation is considered non-preferred and requires prior authorization. These requests require medical records documenting an allergic response, adverse reaction, or inadequate response to the Brand Name formulation. For the most up to date list of drugs where the Brand Name formulation is preferred, see the MassHealth Brand Name Preferred Over Generic Drug List (BOGL) at www.mass.gov/druglist.
5. The following quantity limits apply:

Trintellix (vortioxetine)	30 tablets per 30 days
Viibryd (vilazodone)	30 tablets per 30 days
Auvelity (dextromethorphan/bupropion)	60 tablets per 30 days
Aplenzin (bupropion hydrobromide ER)	30 tablets per 30 days
Pristiq (desvenlafaxine succinate ER)	30 tablets per 30 days
Wellbutrin® XL (bupropion hydrochloride extended-release)	30 tablets per 30 days

Appendix

MassHealth Pediatric Behavioral Health Medication Initiative

The Pediatric Behavioral Health Medication Initiative requires prior authorization for members <18 of age for behavioral health medication classes and/or specific medication combinations (i.e., polypharmacy) that have limited evidence for safety and efficacy in the pediatric population. The aspects of the **Pediatric Behavioral Health Medication Initiative** that may apply to the antidepressant guideline include the following:

1. Behavioral health medication polypharmacy (pharmacy claims for 4 or more behavioral health medications [i.e., alpha2 agonists, antidepressants, antipsychotics, atomoxetine, benzodiazepines,

buspirone, cerebral stimulants, donepezil, hypnotic agents, memantine, modafinil, mood stabilizers, naltrexone, and viloxazine] filled within a 45-day period)
2. Antidepressant polypharmacy (overlapping pharmacy claims for 2 or more antidepressants for ≥60 days within a 90-day period)
3. Antidepressant pharmacy claim for pediatric members less than 6 years old

Please refer to the **Pediatric Behavioral Health Medication Initiative** guideline to assess appropriateness of therapy when reviewing prior authorization requests for pediatric members <18 years of age.

Emsam® (selegiline) and tyramine restricted diet

If the request states that the member is unable to adhere to a MAOI tyramine-restricted diet, the 6 mg patch may be approvable; the use of the 9 mg patch and 12 mg patch still require dietary restrictions per package labeling.

For members <18 years of age, all requests for antidepressants will also be reviewed using additional criteria in the **Pediatric Behavioral Health Medication Initiative** guideline.

Paraphilias

Paraphilias (deviant sexual behavior):

- Can be treated with SSRIs (at typical antidepressant doses), TCAs, hormonal treatments with steroidal antiandrogens (e.g. medroxyprogesterone), or GnRH analogues
- Compelling requests for paraphilias may be approved:
    - If member was recently hospitalized and received requested medication during hospitalization -> Approval duration 1 year
    - If request is for 2 SSRIs, 2 SNRIs, SSRI + venlafaxine, or SSRI + duloxetine -> Approval duration for 6 months

For members <18 years of age, all requests for antidepressants will also be reviewed using additional criteria in the **Pediatric Behavioral Health Medication Initiative** guideline.

Requests for Desvenlafaxine Succinate Exceeding Quantity Limits

High doses of SSRIs and SNRIs may be clinically necessary in patients not responding to alternative therapies or with diagnoses such as OCD.

Requests exceeding established quantity limits of 1 unit/day documenting a partial response to FDA-approved dosing and failure to respond to alternative antidepressants can be approved up to 2 units/day for a total daily dose of 150 mg/day.

References

1. Simon G. Unipolar major depression in adults: Choosing initial treatment. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2020 [cited 2020 Feb 4]. Available from: http://www.utdol.com/utd/index.do
2. Micromedex® Healthcare Series [database on the Internet]. Greenwood Village (CO): Thomson Healthcare; Updated periodically [cited 2020 Feb 4]. Available from: http://www.thomsonhc.com/.

3. EMSAM® [package insert]. Tampa (FL): Somerset Pharmaceuticals, Inc; 2015 Mar.
4. Marplan® [package insert]. Parsippany (NJ): Validus Pharmaceuticals, LLC; 2012 Mar.
5. Fetzima® [package insert on the internet]. St. Louis (MO): Forest Pharmaceuticals, Inc.; 2014 Jul.
6. Khedezla® [package insert on the internet]. Wilmington (NC): Osmotica Pharmaceutical Corp.; 2013 Jul.
7. Pristiq® [package insert]. Philadelphia (PA): Wyeth Pharmaceuticals; 2016 Jul.
8. Luvox CR® [package insert]. Palo Alto (CA): Jazz Pharmaceuticals; 2014 Jul.
9. Paxil CR® [package insert]. Research Triangle Park (NC): GlaxoSmithKline; 2014 Jun.
10. Pexeva® [package insert]. Miami (FL): Noven Therapeutics; 2014 Jul.
11. Prozac® (fluoxetine) [package insert]. Indianapolis (IN): Eli Lilly and Company; 2009.
12. Sarafem® (fluoxetine) [package insert]. Indianapolis (IN): Eli Lilly and Company; 2014 Oct.
13. Oleptro® [package insert]. Princeton (NJ): Angelini Labopharm, LLC; 2014 Jun.
14. Trazodone [package insert]. Sellersville (PA): Teva Pharmaceuticals; 2013 Jun.
15. Trintellix® [package insert on the internet] Deerfield (IL): Takeda Pharmaceuticals, Inc. and Lundbeck; 2016 May.
16. Viibryd® [package insert]. St. Louis (MO): Forest Pharmaceuticals, Inc.; 2015 Mar.
17. Anafranil® [package insert]. Hazelwood (MO): Mallinckrodt Inc.; 2014 Jun.
18. Norpramin® [package insert]. Bridgewater (NJ): Sanofi-Aventis; 2014 Jul.
19. Tofranil-PM® [package insert]. Hazelwood (MO): Mallinckrodt Inc; 2014 Jul.
20. Aplenzin® [package insert]. Bridgewater (NJ): sanofi-aventis U.S. LLC; 2014 Dec.
21. Forfivo® [package insert]. Austin (TX): Edgemon Pharmaceuticals; 2014 June.
22. Wellbutrin XL® (bupropion extended-release) [package insert]. Research Triangle Park (NC): GlaxoSmithKline; 2014 Dec.
23. Remeron SolTab® [package insert]. Whitehouse Station (NJ): Merck & Co.; 2016 Jul.
24. Symbyax® (fluoxetine/olanzapine) [package insert]. Indianapolis (IN): Eli Lilly and Company; 2014 Dec.
25. Spravato® [package insert]. Titusville (NJ): Janssen Pharmaceuticals.; 2019 Mar.
26. Zulresso® [package insert]. Cambridge (MA): Sage Pharmaceuticals.; 2019 Jun.
27. Drizalma Sprinkle® [package insert]. Mohali (India): Sun Pharmaceutical Industries Limited; 2019 Jul.
28. Sertraline capsules [package insert]. Morristown (NJ): Almatica Pharma LLC.;2021 Oct.
29. Citalopram capsules [package insert]. Morristown (NJ): Almatica Pharma LLC.; 2022 Jan.
30. Garcia FD, Thibaut F. Current Concepts in the Pharmacotherapy of Paraphilias. Drugs. 2011; 71(6):771-90.
31. Spindler MA, Tarsy D. Initial pharmacologic treatment in Parkinson disease. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2020 [cited 2020 Feb 4]. Available from: http://www.utdol.com/utd/index.do.
32. Nelson C. Serotonin-norepinephrine reuptake inhibitors (SNRIs): Pharmacology, administration, and side effects. UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Oct 1]. Available from: http://www.utdol.com/utd/index.do
33. Hirsch M, Birnbaum RJ. Tricyclic and tetracyclic drugs: Pharmacology, administration, and side effects. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Oct 1]. Available from: http://www.utdol.com/utd/index.do
34. Goldenberg DL. Initial treatment of fibromyalgia in adults. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Oct 1]. Available from: http://www.utdol.com/utd/index.do
35. Feldman EL. Management of diabetic neuropathy. In: Basow DS (Ed). UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Oct 1]. Available from: http://www.utdol.com/utd/index.do
36. Ortega E. Postherpetic neuralgia. UpToDate [database on the internet]. Waltham (MA): UpToDate; 2021 [cited 2021 Oct 1]. Available from: http://www.utdol.com/utd/index.do

37. Auvelity® [package insert]. New York (NY): Axsome Therapeutics, Inc.; 2022 October [cited 2022 Oct 31]

Review History

02/08/2023 - Reviewed and created for Feb P&T; matched MH UPPL. Effective 4/1/23.
4/12/23 – Reviewed and updated for Apr P&T. Added appendix criteria into criteria per NCQA standards. Added antidepressant polypharmacy to criteria. Added Auvelity® (dextromethorphan/ bupropion) and Fetzima® (levomilnacipran) to policy. Added quantity limits for: Fetzima, Trintellix, Viibryd, Auvelity, Aplenzin, Pristiq, Wellbutrin XL. Removed maprotiline from policy due to obsolete status. Effective 6/5/23
05/10/23 – Reviewed and updated for P&T. Admin update to allow Spravato be available through both the pharmacy and medical benefits with PA. Effective 7/1/23.
07/12/23 – Reviewed and updated for P&T. Formatting updates to drug table. Simplified approvable diagnoses. Brand preferred and mandatory generic language was added under Limitations. Clarified polypharmacy description. Effective 7/31/23.
11/15/23 – Reviewed and updated for P&T. Viibryd removed from BOGL (no longer brand preferred). No clinical changes. Effective 12/4/23