Antidepressant Step Therapy with Quantity Limit

STEP THERAPY CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
Meets	**TARGET AGENT(S)** **Aplenzin** (bupropion) **Auvelity** (dextromethorphan-bupropion) **Celexa** (citalopram)* **Citalopram** (capsules)^ **Desvenlafaxine ER** (tablets)^ **Effexor** (venlafaxine)* **Effexor XR** (venlafaxine extended release)* **Fetzima** (levomilnacipran extended release) **Fluoxetine 60 mg** (tablets)*^ **Forfivo XL** (bupropion extended release) **Lexapro** (escitalopram)* **Maprotiline** (tablets)^ **Paxil** (paroxetine hydrochloride)* **Paxil CR** (paroxetine extended release)* **Pexeva** (paroxetine mesylate) **Pristiq** (desvenlafaxine succinate)* **Prozac** (fluoxetine)* **Fluoxetine delayed release** (capsules)^ **Remeron** (mirtazapine)* **Remeron SolTab** (mirtazapine)* **Sertraline** (capsules)^ **Trintellix** (vortioxetine) **Viibryd** (vilazodone)*

Module	Clinical Criteria for Approval
	Wellbutrin (bupropion)* **Wellbutrin SR** (bupropion extended release)* **Wellbutrin XL** (bupropion extended release)* **Zoloft** (sertraline)* * - available as a generic; generic included as a prerequisite in step therapy program ^ – branded generic product(s) available; targeted in the step therapy program **Brand Antidepressant Agents** (except Cymbalta) will be approved when ONE of the following are met: 1. Information has been provided that indicates the patient has been treated with the requested agent **OR** 2. The prescriber states that the patient has been treated with the requested agent AND is at risk if therapy is changed **OR** 3. The patient has a medication history of use in the past 365 days, intolerance, or hypersensitivity to a generic antidepressant agent - SSRI, SNRI, bupropion, mirtazapine, or vilazodone **OR** 4. The patient has an FDA labeled contraindication to ALL generic antidepressants - SSRI, SNRI, bupropion, mirtazapine or vilazodone **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.
Cymbalta/Drizalma	**TARGET AGENT(S)** **Cymbalta** (duloxetine)* * - available as a generic; generic included as a prerequisite in step therapy program **Cymbalta** will be approved when ONE of the following are met: 1. Information has been provided that indicates the patient has been treated with the requested agent s **OR** 2. The prescriber states the patient has been treated with the requested agent AND is at risk if therapy is changed **OR** 3. The patient's medication history includes use of a generic antidepressant agent - SSRI, SNRI, bupropion, mirtazapine, or vilazodone in the past 365 days **OR** 4. The patient has a diagnosis of neuropathic pain and ONE of the following: A. The patient has a medication history of use in the past 90 days, intolerance, or hypersensitivity to ONE prerequisite agent (i.e., amitriptyline, nortriptyline, desipramine, imipramine, or gabapentin) **OR** B. The patient has an FDA labeled contraindication to ALL prerequisite agents (i.e., amitriptyline, nortriptyline, desipramine, imipramine, or gabapentin) **OR** 5. The patient has a diagnosis of fibromyalgia and ONE of the following: A. The patient has a medication history of use in the past 90 days, intolerance, or hypersensitivity to ONE prerequisite agent (i.e., amitriptyline, nortriptyline, desipramine, imipramine, cyclobenzaprine, gabapentin, or tramadol) **OR** B. The patient has an FDA labeled contraindication to ALL prerequisite agents (i.e., amitriptyline, nortriptyline, desipramine, imipramine, cyclobenzaprine, gabapentin, or tramadol) **OR** 6. The patient has a diagnosis of chronic musculoskeletal pain and ONE of the following:

Module	Clinical Criteria for Approval
	A. The patient has a medication history of use in the past 90 days, intolerance, or hypersensitivity to ONE prerequisite agent (i.e., acetaminophen, oral NSAID, topical NSAID, tramadol, amitriptyline, nortriptyline, desipramine, imipramine, cyclobenzaprine, or gabapentin)**OR** B. The patient has an FDA labeled contraindication to ALL prerequisite agents (i.e., acetaminophen, oral NSAID, topical NSAID, tramadol, amitriptyline, nortriptyline, desipramine, imipramine, cyclobenzaprine, or gabapentin **OR** 7. If using for a diagnosis other than neuropathic pain, fibromyalgia, or musculoskeletal pain, ONE of the following: A. The patient has an intolerance or hypersensitivity to a generic antidepressant - SSRI, SNRI, bupropion, mirtazapine, or vilazodone **OR** B. The patient has an FDA labeled contraindication to ALL generic antidepressants - SSRI, SNRI, bupropion, mirtazapine, or vilazodone **Length of Approval:** 12 months NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met: 1. The requested quantity (dose) does NOT exceed the program quantity limit **OR** 2. The requested quantity (dose) is greater than the program quantity limit AND ONE of the following: A. BOTH of the following: 1. The requested agent does not have a maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support therapy with a higher dose for the requested indication **OR** B. BOTH of the following: 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does not exceed the program quantity limit **OR** C. BOTH of the following: 1. The requested quantity (dose) is greater than the maximum FDA labeled dose for the requested indication **AND** 2. Information has been provided to support therapy with a higher dose for the requested indication **Length of Approval**: up to 12 months