Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: N/A**
Policy Number: PHW.PDL.031	**Effective Date: 01/01/2020** **Revision Date: 07/2020**
Policy Name: Antidepressants, Other	

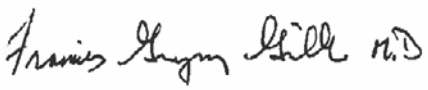
Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Revised Policy***
- ✓ **Annual Review - No Revisions**
- ✓ **Statewide PDL** - *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q3 2020 annual review: no changes.

Name of Authorized Individual (Please type or print): **Francis G. Grillo, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Antidepressants, Other

Reference Number: PHW.PDL.031
Effective Date: 01/01/2020
Last Review Date: 07/2020

Revision Log

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health and Wellness® that Other Antidepressants are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Antidepressants, Other

A. Prescriptions That Require Prior Authorization

Prescriptions for Antidepressants, Other that meet any of the following conditions must be prior authorized:

1. A non-preferred Antidepressant, Other.

2. An Antidepressant, Other with a prescribed quantity that exceeds the quantity limit.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Antidepressant, Other, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Is prescribed the Antidepressant, Other for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

2. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

3. Is prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

4. Does not have a history of a contraindication to the prescribed medication; **AND**

5. For Spravato (esketamine), **all** of the following:

a. Is prescribed Spravato (esketamine) by or in consultation with a psychiatrist,
b. Has a documented diagnosis of treatment-resistant moderate-to-severe major depressive disorder,
c. Is prescribed Spravato (esketamine) in conjunction with a therapeutic dose of an oral antidepressant,
d. Does not have severe hepatic impairment (Child-Pugh class C);

AND

6. For a non-preferred Antidepressant, Other, **one** of the following:

   a. At least **two** of the following:
      i. Has a history of therapeutic failure, contraindication, or intolerance of the preferred Antidepressants, Other approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,
      ii. Has a history of therapeutic failure, contraindication, or intolerance of the Antidepressants, SSRIs approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,
      iii. Has a history of therapeutic failure, contraindication, or intolerance to augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant approved or medically accepted for the beneficiary's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks;

   b. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antidepressant, Other;

   AND

7. If a prescription for an Antidepressant, Other is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

FOR RENEWALS OF PRIOR AUTHORIZATION FOR ANTIDEPRESSANTS, OTHER: The determination of medical necessity of a request for renewal of a prior authorization for an Antidepressant, Other that was previously approved will take into account whether the beneficiary:

1. Is prescribed a dose and frequency that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

2. Does not have a history of a contraindication to the prescribed medication; **AND**

3. For Spravato (esketamine), **all** of the following:

    a. Is prescribed Spravato (esketamine) by or in consultation with a psychiatrist,
    b. Is prescribed Spravato (esketamine) in conjunction with a therapeutic dose of an oral antidepressant,
    c. Has documentation of improvement in disease severity since initiating treatment,
    d. Does not have severe hepatic impairment (Child-Pugh class C).

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for an Antidepressant, Other. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. **Approval Duration:**

For Spravato (esketamine), requests will be approved for 6 months.

All other requests may be approved for 12 months.

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020