Clinical Policy: Antidepressants, Other

Reference Number: PHW.PDL.031
Effective Date: 01/01/2020
Last Review Date: 11/2024

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 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 member:

1. For Zulresso (brexanolone) and Zurzuvae (zuranolone), all of the following:

   a. Is prescribed Zulresso (brexanolone) or Zurzuvae (zuranolone) for an indication that is included in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication,

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

   c. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,

   d. Will not use Zulresso (brexanolone) and Zurzuvae (zuranolone) concomitantly,

   e. For a diagnosis of postpartum depression (PPD), all of the following:

i. Has depression with onset in the third trimester through 4 weeks postpartum,
ii. Has moderate to severe PPD based on a validated depression rating scale (e.g., PHQ-9/EPDS, HAMD-17),
iii. Is ≤12 months postpartum,
iv. Is not actively psychotic, manic, or hypomanic,
v. Is not currently pregnant;

AND

2. For all other non-preferred Antidepressant, Other, **one** of the following:

a. Has a current history (within the past 90 days) of being prescribed the same non-preferred Antidepressant, Other (does not apply to non-preferred brands when the therapeutically equivalent generic is preferred or to non-preferred generics when the therapeutically equivalent brand is preferred)

b. **All** of the following:

i. 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,

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

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

iv. Does not have a history of a contraindication to the prescribed medication;

v. At least **two** of the following:

a) Has a history of therapeutic failure, contraindication, or intolerance of the preferred Antidepressants, Other approved or medically accepted for the member's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,
b) Has a history of therapeutic failure, contraindication, or intolerance of the Antidepressants, SSRIs approved or medically accepted for the member's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,
c) Has a history of therapeutic failure, contraindication, or intolerance of augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant approved or medically accepted for the member's diagnosis at maximally tolerated doses for a duration of ≥ 6 weeks,

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. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
   d. Does not have severe hepatic impairment (Child-Pugh class C);

   AND

4. 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 member 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 member, 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 member:

1. For a non-preferred Antidepressant, Other with a therapeutically equivalent brand or generic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand or generic that would not be expected to occur with the requested medication; **AND**

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

   a. Has documentation of improvement in disease severity since initiating treatment,
   b. Is prescribed Spravato (esketamine) by or in consultation with a psychiatrist,
   c. Is prescribed Spravato (esketamine) in conjunction with a therapeutic dose of an oral antidepressant,
   d. Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature,
   e. Does not have severe hepatic impairment (Child-Pugh class C);

   AND

3. If a prescription for an Antidepressant, Other is for 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 member 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 member, the request for prior authorization will be approved.

B. 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 member.

C. **Approval Duration:**

For Zulresso (brexanolone) and Zurzuvae (zuranolone), requests will be approved for one treatment course per pregnancy based on FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

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
Q1 2021: policy revised according to DHS revisions effective 01/05/2021	11/2020
Q1 2022 annual review: no changes.	11/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024: policy revised according to DHS revisions effective 01/08/2024	11/2023
Q3 2024: policy revised according to DHS revisions effective 07/15/2024	06/2024
Q1 2025: policy revised according to DHS revisions effective 01/06/2025	11/2024