Antidepressant Agents
Step Therapy and
Quantity Limit Program Summary

This program applies to FlexRx Open, GenRx Open, Health Insurance Marketplace, FocusRx and KeyRx.

This is a FlexRx standard and GenRx standard step therapy program.

The BCBS MN Step Therapy Supplement also applies to this program for all Commercial/HIM lines of business.

Program specific denial language for prerequisite step therapy component does not apply. Instead, supplemental program denial language will apply.

<table>
<thead>
<tr>
<th>Agent</th>
<th>MDD</th>
<th>OCD</th>
<th>PD</th>
<th>GAD</th>
<th>SAD</th>
<th>PDD</th>
<th>PTSD</th>
<th>Bulimia</th>
<th>Other Diagnoses</th>
<th>Dosing (adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selective Serotonin Reuptake Inhibitors (SSRIs)</strong></td>
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<tr>
<td><strong>Celexa®</strong> (citalopram) tablets, oral solution</td>
<td>✓</td>
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<td>MDD: 20 mg/day up to 40 mg/day; doses above 40 mg/day are not recommended due to the risk of QT prolongation. 20 mg/day is maximum recommended dose for CYP2C19 poor metabolizers, patients taking cimetidine or another CYP2C19 inhibitor, with hepatic impairment, or age &gt;60</td>
</tr>
<tr>
<td><strong>Fluoxetine 60 mg tablets</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td>MDD, OCD, PD, Bulimia: 60 mg/day</td>
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<tr>
<td><strong>Fluvoxamine ER capsules</strong></td>
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<td>OCD: 100-300 mg/day</td>
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<tr>
<td><strong>Fluvoxamine tablets</strong></td>
<td></td>
<td>✓</td>
<td>✓</td>
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<td>OCD: 50 mg/day as a single dose titrated up to 100-300 mg/day (divided twice daily)</td>
</tr>
</tbody>
</table>
| **Lexapro®** (escitalopram) tablets, oral solution | ✓ | ✓ | | | | | | | | MDD: 10-20 mg/day  
GAD: 10 mg/day |
| **Paxil®** (paroxetine) tablets, oral suspension | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | | | | MDD: 20-50 mg/day  
OCD: 20-60 mg/day (target 40 mg/day)  
PD: 10-60 mg/day (target 40 mg/day)  
GAD: 20-50 mg/day (target 20 mg/day)  
SAD: 20-60 mg/day (target 20 mg/day)  
PTSD: 20-50 mg/day (target 20 mg/day) |
| **Paxil CR®** (paroxetine CR) tablets | ✓ | ✓ | | | | ✓ | ✓ | | MDD: 25-62.5 mg/day  
PD: 12.5-75 mg/day  
SAD: 12.5-37.5 mg/day  
PDD: 12.5-25 mg/day (daily throughout cycle or limited to luteal phase) |
| **Pexeva®** (paroxetine mesylate) tablets | ✓ | ✓ | ✓ | | | | | | | MDD: 20-50 mg/day  
OCD: 20-60 mg/day (target 40 mg/day)  
PD: 10-60 mg/day (target 40 mg/day)  
GAD: 20-50 mg/day (target 20 mg/day) |
<table>
<thead>
<tr>
<th>Agent</th>
<th>MDD</th>
<th>OCD</th>
<th>PD</th>
<th>GAD</th>
<th>SAD</th>
<th>PDD</th>
<th>PTSD</th>
<th>Bulimia</th>
<th>Other Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prozac® Weekly</strong> (fluoxetine DR) capsules</td>
<td>✓</td>
<td></td>
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<td></td>
<td>MDD: 90 mg once weekly</td>
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<tr>
<td><strong>Prozac®</strong> (fluoxetine) tablets, capsules, oral solution</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>MDD, OCD: 20-80 mg/day Bulimia: 60 mg/day PD: Initially 10 mg/day; titrated to 20 mg/day; up to 60 mg/day</td>
</tr>
<tr>
<td><strong>Zoloft®</strong> (sertraline) tablets, oral concentrate</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>MDD, OCD: Initially 50 mg/day PD, PTSD, SAD: Initial titration 25 to 50 mg/day; Range: 50-200 mg/day PDD: Initially 50 mg/day (daily throughout cycle or luteal phase only); Range: 50-100 mg/day for luteal phase only; up to 150 mg/day if taken throughout cycle</td>
</tr>
</tbody>
</table>

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Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)

<table>
<thead>
<tr>
<th>Agent</th>
<th>MDD</th>
<th>OCD</th>
<th>PD</th>
<th>GAD</th>
<th>SAD</th>
<th>PDD</th>
<th>PTSD</th>
<th>Bulimia</th>
<th>Other Diagnoses</th>
</tr>
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<tbody>
<tr>
<td><strong>Cymbalta®</strong> (duloxetine DR) capsules</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>MDD: 20 mg twice daily to 60 mg/day (once or divided twice daily); may titrate from 30 to 60 mg once daily GAD: 60 mg/day (titrate from 30 mg/day) MDD, GAD: 120 mg/day shown effective but no evidence of added benefit and more adverse effects from doses &gt;60 mg/day DPNP: 60 mg/day FM, CMP: 30 mg/day x one week; then 60 mg/day no evidence of added benefit and more adverse effects from doses &gt;60 mg/day</td>
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<tr>
<td><strong>Desvenlafaxine ER</strong> tablets</td>
<td>✓</td>
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<td></td>
<td></td>
<td>MDD: 50 mg/day (range 50-400 mg/day); no evidence of additional benefit and more adverse effects from doses &gt;50 mg/day</td>
</tr>
<tr>
<td><strong>Duloxetine DR</strong> capsules</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>MDD: 40 mg/day – 120 mg/day; no evidence of additional benefit for doses &gt;60 mg/day GAD: 30 mg/day – 120 mg/day; no evidence of additional benefit for doses &gt;60 mg/day DPNP: 60 mg/day; no evidence of additional benefit for doses &gt;60 mg/day CMP: 30 mg/day – 60 mg/day; no evidence of additional benefit for doses &gt;60 mg/day</td>
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<tr>
<td><strong>Effexor®</strong> (venlafaxine) tablets</td>
<td>✓</td>
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<td>MDD: In 2-3 divided doses, 75-225 mg/day (moderately depressed outpatients); up to 350 mg/day (severely depressed inpatients) Maximum 375 mg/day in divided doses</td>
</tr>
</tbody>
</table>

MDD=major depressive disorder; OCD= obsessive compulsive disorder; PD= panic disorder; GAD= generalized anxiety disorder; SAD= social anxiety disorder or social phobia; PDD= premenstrual dysphoric disorder; PTSD= post traumatic stress disorder; DPNP=diabetic peripheral neuropathic pain; FM=fibromyalgia; CMP=chronic musculoskeletal pain; ER=extended release, ODT=orally disintegrating
<table>
<thead>
<tr>
<th>Agent</th>
<th>MDD</th>
<th>OCD</th>
<th>PD</th>
<th>GAD</th>
<th>SAD</th>
<th>PDD</th>
<th>Bulimia</th>
<th>Other Diagnoses</th>
<th>Dosing (adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effexor XR</strong>&lt;sup&gt;®&lt;/sup&gt;</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td>MDD, GAD, PD: Initially 37.5 mg/day for 7 days; then range of 75-225 mg/day</td>
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<tr>
<td>(venlafaxine ER) capsules</td>
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<td>SAD: 75 mg/day</td>
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<tr>
<td><strong>Fetzima</strong>&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
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<td>MDD: initial 20 mg once daily, then 40 mg once daily. Based on efficacy/tolerability, increase in increments of 40 mg at intervals of &gt;2 days. Range is 40 mg-120 mg once daily. Maximum recommended dose is 120 mg once daily.</td>
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<tr>
<td>(levomilnacipran ER) capsules</td>
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<tr>
<td><strong>Kheedzla</strong>&lt;sup&gt;®&lt;/sup&gt;</td>
<td>✓</td>
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<td></td>
<td>MDD: 50 mg/day (range 50-400 mg/day); no evidence of additional benefit and more adverse effects from doses &gt;50 mg/day</td>
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<td>(desvenlafaxine ER) tablets</td>
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<tr>
<td><strong>Irenka</strong>&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td></td>
<td>DPNP</td>
<td>CMP</td>
<td>MDD: 40 mg/day – 120 mg/day; no evidence of additional benefit for doses &gt;60 mg/day GAD: 30 mg/day – 120 mg /day; no evidence of additional benefit for doses &gt;60 mg/day DPNP: 60 mg/day; no evidence of additional benefit for doses &gt;60 mg/day CMP: 30 mg/day – 60 mg/day; no evidence of additional benefit for doses &gt;60 mg/day</td>
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<tr>
<td>(duloxetine DR) capsules</td>
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<tr>
<td><strong>Pristiq</strong>&lt;sup&gt;®&lt;/sup&gt;</td>
<td></td>
<td>✓</td>
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<td></td>
<td>MDD: 50 mg/day (range 50-400 mg/day); no evidence of additional benefit and more adverse effects from doses &gt;50 mg/day</td>
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<tr>
<td>(desvenlafaxine succinate)</td>
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<tr>
<td><strong>Venlafaxine ER tablets</strong></td>
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<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td>MDD: Initially 37.5 to 75 mg/day; range of 75-225 mg/day SAD: 75 mg/day</td>
</tr>
</tbody>
</table>

MDD=major depressive disorder; OCD= obsessive compulsive disorder; PD= panic disorder; GAD= generalized anxiety disorder; SAD= social anxiety disorder or social phobia; PDD= premenstrual dysphoric disorder; PTSD= post traumatic stress disorder; DPNP=diabetic peripheral neuropathic pain; FM=fibromyalgia; CMP=chronic musculoskeletal pain; CR= controlled release; DR=delayed release; ER=extended release, ODT=orally disintegrating

**Other Antidepressants**

<table>
<thead>
<tr>
<th>Agent</th>
<th>MDD</th>
<th>OCD</th>
<th>PD</th>
<th>GAD</th>
<th>SAD</th>
<th>PDD</th>
<th>Bulimia</th>
<th>Other Diagnoses</th>
<th>Dosing (adults)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aplenzin</strong>&lt;sup&gt;®&lt;/sup&gt; (bupropion ER) tablets</td>
<td>✓</td>
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<td></td>
<td>✓ SAFD</td>
<td>MDD: Initially, 174 mg/day; usual target dose is 348 mg/day; consider maximum dose 522 mg/day if no response to 348 mg</td>
</tr>
<tr>
<td><strong>Forfivo XL</strong>&lt;sup&gt;®&lt;/sup&gt; (bupropion ER) tablets</td>
<td>✓</td>
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<td>MDD: Initially start with another formulation of bupropion until a patient has been on 300mg of bupropion per day for at least 2 weeks, and requires a dosage of 450mg per day</td>
</tr>
<tr>
<td>Agent</td>
<td>MDD</td>
<td>OCD</td>
<td>PD</td>
<td>GAD</td>
<td>SAD</td>
<td>PDD</td>
<td>PTSD</td>
<td>Bulimia</td>
<td>Other Diagnoses</td>
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<tr>
<td>Maprotiline tablets</td>
<td>✓</td>
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<td>MDD: 25 mg three times daily; may increase by 25-50 mg/day at weekly intervals depending on response. Usual dose: 75-150 mg/day (single dose at bedtime or divided). Maximum of 150-220 mg/day (1-3 doses)</td>
</tr>
<tr>
<td>Oleptro® (trazodone ER) tablets</td>
<td>✓</td>
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<td>MDD: Initially 150 mg once daily; increase by 75 mg/day; maximum 375 mg/day</td>
</tr>
<tr>
<td>Remeron®, Remeron SolTab® (mirtazapine) tablets, ODT tablets</td>
<td>✓</td>
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<td></td>
<td></td>
<td>MDD: initially 15 mg/day; range 15-45 mg/day</td>
</tr>
<tr>
<td>Trintellix® (vortioxetine) tablets</td>
<td>✓</td>
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<td>MDD: Initially, 10 mg once daily; increase to 20 mg/day as tolerated. Efficacy and safety of doses above 20 mg/day have not been evaluated.</td>
</tr>
<tr>
<td>Viiibryd® (vilazodone) tablets</td>
<td>✓</td>
<td></td>
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<td></td>
<td>MDD: Initially, 10 mg/day for 7 days; then 20 mg/day for 7 days; then 40 mg/day (recommended dose).</td>
</tr>
<tr>
<td>Wellbutrin® (bupropion), Wellbutrin SR® (bupropion SR) tablets</td>
<td>✓</td>
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<td></td>
<td>MDD - Wellbutrin: Initially 100 mg twice daily; may increase to 100 mg three times daily; Maximum of 450 mg/day (divided doses &lt; 150 mg each) MDD - Wellbutrin SR: Initially 150 mg once daily; then 150 mg twice daily as early as day 4; Maximum of 200 mg twice daily.</td>
</tr>
<tr>
<td>Wellbutrin XL® (bupropion ER) tablets</td>
<td>✓</td>
<td>✓</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>MDD: 150 mg/day titrated to 300 mg/day as early as day 4; Maximum 450 mg/day. SAFD: 150 mg/day for one week; then 300 mg/day (target dose).</td>
</tr>
</tbody>
</table>

MDD=major depressive disorder; OCD=obsessive compulsive disorder; PD=panic disorder; GAD=generalized anxiety disorder; SAD=social anxiety disorder or social phobia; PDD=premenstrual dysphoric disorder; PTSD=post traumatic stress disorder; DPNP=diabetic peripheral neuropathic pain; FM=fibromyalgia; CMP=chronic musculoskeletal pain; SAFD=Seasonal Affective Disorder; CR=controlled release; DR=delayed release; ER=extended release; ODT=orally disintegrating; SR=sustained release

**CLINICAL RATIONALE**

**Depression**

Selective serotonin reuptake inhibitors (SSRIs) along with serotonin norepinephrine reuptake inhibitors (SNRIs), bupropion, and mirtazapine are considered first line treatment options for adults with major depressive disorder (MDD). The choice of medication is based on patient preference, a psychiatric disorder that may specifically respond to a particular class, previous treatment response, side effect profiles, family history of response, concurrent medical illnesses, concurrently prescribed medications, and cost of medication. Although all these drugs may have similar efficacy, they differ significantly in their side effect profiles. Patients who cannot tolerate one agent may do well with another.43,45,46

**Anxiety Disorders**

Guidelines for treatment of anxiety include several anxiety-related conditions: obsessive compulsive disorder (OCD), panic disorder (PD), social anxiety disorder (SAD), post-traumatic stress disorder (PTSD), and generalized anxiety disorder (GAD). SSRIs or SNRIs (e.g. venlafaxine) are efficacious for the treatment of GAD. Although all these drugs may have similar efficacy, they differ significantly in their side effect profiles. Treatment choice is typically based on several factors including patient preference and medical history, side effect profile,
and drug interactions. If effective, antidepressant treatment for GAD should be continued for at least 12 months.\textsuperscript{41,44,47}

**Neuropathic Pain**

Treatment for neuropathic pain include TCAs, gabapentin, pregabalin, and SNRI antidepressants (duloxetine [most studied], venlafaxine) as first-line therapies.\textsuperscript{21,22} For patients with diabetic neuropathy, an antidepressant (e.g., amitriptyline, duloxetine, venlafaxine) or anticonvulsant (e.g., pregabalin) is recommend as initial therapy. Available evidence suggests these agents have similar modest benefit, though few high-quality comparative trials have been done. Among these options, the preference is to start with amitriptyline, particularly in younger healthier patients. Patients who fail to improve with a reasonable trial of one of these agents can be switched to monotherapy with another agent. For patients who do not improve on one drug, suggest combination therapy employing two drugs from different medication classes as the next step in the treatment paradigm. For patients who are unable to tolerate any of these drugs, alternative treatments include capsaicin cream, lidocaine patch, alpha-lipoic acid, isosorbide dinitrate topical spray, and transcutaneous electrical nerve stimulation.\textsuperscript{48} Due to risk of addiction, abuse, sedation, and other complications associated with opioid use, opioids are not recommended for treatment of neuropathic pain.\textsuperscript{22,48}

**Fibromyalgia**

Nonpharmacological therapy should be first-line therapy and then if there is a lack of effect, therapy should be individualized according to patient need, which may include pharmacological therapy. Pharmacologic therapies include: duloxetine, milnacipran, tramadol, pregabalin, cyclobenzaprine. Strength of recommendation for all these options is weak.\textsuperscript{23,49} A review (2015) suggests pharmaceuticals (e.g., pregabalin, duloxetine, milnacipran) will provide clinically meaningful improvement without any major adverse events for a relatively small subset of patients only. In many other patients, the benefits do not outweigh the adverse effects, while the remainder do not experience any symptom improvement or even get worse.\textsuperscript{23,50}

Pharmacological therapy should be guided by predominant symptoms that accompany pain. All patients should have a good therapeutic trial of a low-dose tricyclic compound (e.g., cyclobenzaprine, amitriptyline, or nortriptyline). Patients with comorbid depression or fatigue should next try a serotonin norepinephrine reuptake inhibitor (SNRI). Patients with comorbid anxiety or sleep issues should next try a gabapentinoid. It is often necessary to use several classes of drugs together. Use of opioids is discouraged. Nonsteroidal anti-inflammatory drugs (NSAIDs) and acetaminophen can be used to treat comorbid peripheral pain generators.\textsuperscript{25}

Tramadol may be used in patients who require additional pain relief on a temporary basis for exacerbations or for patients who have inadequate pain control with other therapies.\textsuperscript{51}

**Chronic Musculoskeletal Pain**

The American Psychiatric Association recommends the use of TCAs and SNRIs for treating chronic pain and comorbid depression.\textsuperscript{28} SNRIs, which target both serotonin and norepinephrine, have a greater analgesic effect than antidepressants targeting either neurotransmitter alone. Duloxetine and venlafaxine have effectively reduced symptoms in patients with pain disorders and comorbid depression.\textsuperscript{31}

Duloxetine is indicated for the management of chronic musculoskeletal pain, which was established in studies of patients with chronic low back pain and chronic pain due to osteoarthritis (OA).\textsuperscript{13} A guideline on treatment of chronic noncancer pain including neuropathic, somatic, myofascial and visceral types of pain (American Society of Anesthesiologists, 2010) includes anticonvulsants, antidepressants (TCAs and SNRIs), benzodiazepines, NMDA receptor antagonists, NSAIDs, opioids, skeletal muscle relaxants, and topical agents as part of a multimodal strategy for a variety of patients with chronic pain.\textsuperscript{31}
Adverse Effects

SSRIs
SSRIs commonly cause nausea, vomiting, diarrhea, nervous activation (e.g., insomnia, restlessness, anxiety), and headaches and these may dissipate over time. Although sexual dysfunction (e.g., loss of libido, erectile/ejaculatory problems) can occur with any antidepressant, this appears to be more common with SSRIs, and may also disappear with time. Paroxetine is associated with a higher incidence of weight gain than other SSRIs. Serotonin syndrome is associated with simultaneous use of SSRIs plus other serotonergic agents (e.g., monoamine oxidase inhibitors [MAOIs]) and should be avoided. SSRIs should not be abruptly discontinued to avoid discontinuation syndrome; most likely with paroxetine, least likely with fluoxetine.\(^\text{28}\)

Citalopram doses above 40 mg/day are not recommended due to the risk of QT prolongation; 20 mg/day is the maximum recommended dose for CYP2C19 poor metabolizers or those patients taking a CYP2C19 inhibitor.\(^\text{4}\) Citalopram should not be used in patients with QT syndrome, bradycardia, hypokalemia, hypomagnesemia, recent acute myocardial infarction, uncompensated heart failure, or with other drugs that prolong the QTc interval. Patients at risk for electrolyte disturbances should have baseline serum potassium and magnesium checked with periodic monitoring.\(^\text{4,24}\)

SNRIs
SNRI side effects are similar with those of SSRIs (nausea, vomiting, nervous activation, sexual dysfunction) and may attenuate with continued use. SNRI effects are also more likely to reflect noradrenergic activity (increased pulse, dilated pupils, dry mouth, excess sweating, and constipation). All three SNRIs have a risk of increased blood pressure, especially at higher doses. As with SSRIs, serotonin syndrome is associated with simultaneous use of SNRIs plus other serotonergic agents (e.g., MAOIs) and should be avoided. Like SSRIs, SNRIs should not be abruptly discontinued to avoid discontinuation syndrome; more likely with venlafaxine and desvenlafaxine than duloxetine.\(^\text{28}\)

Vortioxetine
Most common adverse reactions in patients on vortioxetine were nausea, constipation and vomiting.\(^\text{38}\)

Vilazodone
Most common adverse effects of vilazodone in clinical trials were diarrhea, nausea, vomiting, and insomnia. Vilazodone is an SSRI and partial serotonergic 5-HT\(_{1a}\) agonist. Like SSRIs and SNRIs, the drug is associated with serotonin and discontinuation syndromes, and should not be given with other serotonergic agents or discontinued abruptly.\(^\text{30}\)

Bupropion
Bupropion has fewer sexual side effects than other antidepressants. Neurologic adverse effects include headache, tremors, and seizures. Risk of seizures is minimized by avoiding high doses, avoiding rapid titration, using divided dosing schedules, avoiding use in patients at risk of seizures. Other side effects may include agitation/nervousness, mild cognitive dysfunction, insomnia, gastrointestinal upset.\(^\text{28}\)

Mirtazapine
Most common side effects of mirtazapine include dry mouth, sedation, and weight gain (greater risk than other antidepressants). Mirtazapine is often given at bedtime and may be chosen for depressed patients with initial insomnia and weight loss. Mirtazapine increases serum cholesterol levels in some patients.\(^\text{28}\)

Trazodone
The most common side effect with trazodone is sedation; this may be an advantage in patients with initial insomnias. Trazodone can also cause cardiovascular side effects, including orthostasis, particularly among elderly patients or those with preexisting heart disease. Use of trazodone has also been associated with life-threatening ventricular arrhythmias in several case reports. Trazodone also can cause sexual side effects, including erectile dysfunction in men; in rare instances, priapism occurs, which might require surgical correction.\textsuperscript{28}

**Maprotiline**

Side effects with maprotiline may be similar to those seen with tricyclic antidepressants (TCAs), and can include cardiovascular effects including arrhythmias, anticholinergic effects, sedation, orthostatic hypotension, weight gain and seizures at therapeutic doses. Potentially dangerous interactions, including hypertensive crises and serotonin syndrome, can develop when TCAs are administered with MAOIs.\textsuperscript{28}

**Serotonin Syndrome**

Serotonin syndrome is presumed to result from high levels of serotonin in the brain. Features of serotonin syndrome include abdominal pain, diarrhea, flushing, sweating, hyperthermia, lethargy, mental status changes, tremor and myoclonus, rhabdomyolysis, renal failure, cardiovascular shock, and possibly death. Although it can occur with administration of one or more serotonergic medications, it is most severe when an MAOI is co-administered with another serotonergic medication (such as an antidepressant).\textsuperscript{28}

Other antidepressants should not be used in patients concomitantly taking an MAOI.\textsuperscript{29}

For additional clinical information see the Prime Therapeutics Formulary Chapters 9.2C Antidepressants: Selective Serotonin Reuptake Inhibitors (SSRI) and 9.2E Antidepressants: Miscellaneous.

**REFERENCES**

44. Trintellix prescribing information. Takeda Pharmaceuticals America, Inc/Lundbeck. October 2018.
Antidepressant Agents Step Therapy

TARGET AGENTS
Aplenzin™ (bupropion)
Celexa® (citalopram)a
Cymbalta® (duloxetine)a
Desvenlafaxine (ER tablets, brand product)
Desvenlafaxine fumarate (ER tablets, brand product)
Duloxetine (delayed release capsule, brand product)
Effexor® (venlafaxine)a
Effexor XR® (venlafaxine extended release)a
Fetzima® (levomilnacipran extended release)
Fluvoxamine extended releasea
Fluoxetine 60 mg (tablets, brand product)a
Forfivo XL® (bupropion extended release)
Irenka™ (duloxetine delayed release)a
Khedezla™ (desvenlafaxine extended release)
Lexapro® (escitalopram)a
Maprotiline (tablets, brand product)
Oleptro™ (trazodone extended release)b
Paxil® (paroxetine hydrochloride)a
Paxil CR® (paroxetine extended release)a
Pexeva® (paroxetine mesylate)
Pristiq® (desvenlafaxine succinate)a
Prozac® (fluoxetine)a
Prozac® Weekly™ (fluoxetine delayed release)a
Remeron® (mirtazapine)a
RemeronSolTab® (mirtazapine)a
Trintellix™ (vortioxetine)
Venlafaxine ER (tablets, brand product)a
Viibryd™ (vilazodone)
Wellbutrin® (bupropion)a
Wellbutrin SR® (bupropion extended release)a
Wellbutrin XL® (bupropion extended release)a
Zoloft® (sertraline)a

a - available as a generic; generic included as a prerequisite in step therapy program
b – generic product anticipated

PRIOR AUTHORIZATION CRITERIA FOR APPROVAL
Brand Antidepressant Agents (except Cymbalta, Duloxetine (delayed release capsule, brand product) and Irenka, see below) will be approved when BOTH of the following are met:
1. The patient has not filled a prescription for a monoamine oxidase (MAO) inhibitor in the past 30 days
   AND
2. ONE of the following:
   a. The patient’s medication history includes use of a generic antidepressant agent - SSRI, SNRI, bupropion, or mirtazapine [or generic trazodone extended-release if it becomes available] in the past 365 days
   OR
   b. There is documentation that the patient is currently being treated with the requested agent
   OR
   c. The prescriber states that the patient is currently being treated with the requested agent AND is at risk if therapy is changed
   OR
d. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE generic antidepressant agent - SSRI, SNRI, bupropion, or mirtazapine [or generic trazodone extended-release if it becomes available]

**Cymbalta, Duloxetine (delayed release capsule, brand product), and Irenka** will be approved when BOTH of the following are met:

1. The patient has **NOT** filled a prescription for a monoamine oxidase (MAO) inhibitor in the past 30 days
   - AND
2. ONE of the following:
   a. The patient’s medication history includes use of a generic antidepressant agent - SSRI, SNRI, bupropion, or mirtazapine [or generic trazodone extended-release if it becomes available] in the past 365 days
   - OR
   b. The patient has a diagnosis of neuropathic pain and has a medication history that includes use of amitriptyline, nortriptyline, desipramine, imipramine, or gabapentin in the past 90 days
   - OR
   c. For Cymbalta only, the patient has a diagnosis of fibromyalgia and has a medication history that includes use of amitriptyline, nortriptyline, desipramine, imipramine, cyclobenzaprine, gabapentin, or tramadol in the past 90 days
   - OR
   d. The patient has a diagnosis of chronic musculoskeletal pain and has a medication history that includes use of acetaminophen, oral NSAID, topical NSAID, tramadol, amitriptyline, nortriptyline, desipramine, imipramine, cyclobenzaprine, or gabapentin in the past 90 days
   - OR
   e. There is documentation that the patient is currently being treated with the requested agent
   - OR
   f. The prescriber states that the patient is currently being treated with the requested agent AND is at risk if therapy is changed
   - OR
   g. The patient has a documented intolerance, FDA labeled contraindication, or hypersensitivity to ONE of the prerequisite agents listed above (e.g. generic antidepressant, amitriptyline, nortriptyline, desipramine, imipramine, cyclobenzaprine, gabapentin, acetaminophen, NSAID or tramadol)

**Length of approval:** 12 months

**NOTE:** If Quantity Limit program also applies, please refer to Quantity Limit documents.
Step Therapy Supplement

This program applies to FlexRx Closed, FlexRx Open, GenRx Closed, GenRx Open, Health Insurance Marketplace, FocusRx and KeyRx formularies.

Please note, this does not include or apply to quantity limit questions.

STEP THERAPY SUPPLEMENT

OBJECTIVE
The intent of the Step Therapy Supplement is to provide additional questions, to ensure compliance to MN Statute 62Q.184. These questions will apply if the step therapy component within a Prior Authorization or Step Therapy program is not able to be approved.

CONDITIONS FOR APPROVAL
The requested agent will be approved when ONE of the following are met:

1. The patient is currently being treated with the requested agent as indicated by ALL of the following:
   a. A statement by the prescriber that the patient is currently taking the requested agent
   AND
   b. A statement by the prescriber that the patient is currently receiving a positive therapeutic outcome on requested agent
   AND
   c. The prescriber states that a change in therapy is expected to be ineffective or cause harm

2. The patient's medication history include the required prerequisite/preferred agent(s) as indicated by:
   a. Evidence of a paid claim(s) within the past 999 days
   OR
   b. The prescriber has stated that the patient has tried the required prerequisite/preferred agent(s) in the past 999 days AND the required prerequisite/preferred agent(s) was discontinued due to lack of effectiveness or an adverse event

3. The prescriber has provided documentation that the required prerequisite/preferred agent(s) cannot be used due to a documented medical condition or comorbid condition that is likely to cause an adverse reaction, decrease ability of the patient to achieve or maintain reasonable functional ability in performing daily activities or cause physical or mental harm

Length of Approval: As per program specific criteria