AETNA BETTER HEALTH®
Non-Formulary Prior Authorization guideline for Antidepressants

The following non-preferred antidepressants require prior authorization:

**Selective Serotonin Reuptake Inhibitors (SSRIs):**
- Brisdelle
- Fluoxetine TABLETS
- Fluoxetine weekly
- Fluvoxamine ER
- Paroxetine ER
- Paroxetine mesylate capsules
- Pexeva
- Trintellix
- Viibryd

**Selective Norepinephrine Reuptake Inhibitors (SNRIs):**
- desvenlafaxine fumarate
- Fetzima
- Khedezla
- Pristiq
- Venlafaxine SR TABS

**Other:**
- Aplenzin
- Forfivo XL
- Nefazodone

**Authorization guidelines**

Non-formulary antidepressants can be authorized for members 18 years of age or older who meet one of the following criteria:

A. Requested agent is FDA-approved for the indication being treated or use is supported by nationally recognized compendia or peer reviewed medical literature

B. If there is a formulary preferred agent available in a different formulation of the same ingredient (e.g., Pexeva, Aplenzin, fluvoxamine ER, Brisdelle, fluoxetine weekly), the member must have a documented trial and failure of that formulary agent

C. If requested agent is for Fluoxetine tablets: member is 7 years of age or older and FDA-approved for the indication being treated or use is supported by nationally recognized compendia or peer reviewed medical literature

D. Member is currently stable on the requested non-formulary antidepressant

Last Review: 1/2019
Previous PARP Approval: 6/2018
Current PARP Approval: 3/2019

Proprietary
**Additional criteria based on indication** (NOTE: criteria do not apply to members who are currently stable on the requested non-formulary antidepressant)

**Major Depressive Disorder or Seasonal Affective Disorder:**

A. Member had documented failure of, or intolerance to three (3) formulary agents from at least two (2) different classes of antidepressants (SSRI, SNRI, bupropion, or mirtazapine) at an adequate dose and duration (at least 4 weeks)

OR

B. Member had documented failure of, or intolerance to two (2) formulary agents AND an acceptable antidepressant augmentation regimen (SSRI or SNRI plus one of the following: bupropion, lithium, atypical antipsychotic, buspirone, or liothyronine) at an adequate dose and duration (at least 4 weeks)

AND

C. One of these trials must be with a preferred formulary agent from the same class (SSRI or SNRI)

**Obsessive-Compulsive Disorder:** Member had documented failure of, or intolerance to three (3) formulary agents (e.g., SSRIs, fluvoxamine, clomipramine) at an adequate dose and duration (at least 4 weeks).

**Panic Disorder or Generalized Anxiety Disorder:** Member had documented failure of, or intolerance to three (3) formulary agents from at least two (2) different classes of antidepressants (e.g., SSRI's or SNRI's) at an adequate dose and duration (at least 4 weeks).

**Hot Flashes Associated with Menopause:**

A. Member had documented failure of, or intolerance to three (3) formulary agents from at least two (2) different classes of
antidepressants (e.g., SSRI's or SNRI's) at an adequate dose and duration (at least 4 weeks).

B. Trial and failure of, intolerance to, or member preference to avoid hormonal therapy

**Prenomenstrual Dysphoric Disorder:** Member had documented failure of, or intolerance to three (3) formulary SSRIs at an adequate dose and duration (at least 4 weeks)

**Additional Information:**
These products are NOT covered for members with the following criteria:
- Use not approved by the FDA; **AND**
- The use is unapproved and not supported by the literature or evidence as an accepted off-label use.

**Approval Duration:**
Initial approval: 1 year

Renewal: 1 year

Renewal: Requires response to therapy

**Quantity Limits:**
- Pristiq, desvenlafaxine, Trintellix, Viibryd, Fetzima, Aplenzin, Forfivo XL, paroxetine ER:
  - 1 tablet/capsule per day

- Pexeva:
  - 10mg and 20mg: 1 tablet per day
  - 30mg: 2 tablets per day
  - 40mg: 1.5 tablets per day

- Fluoxetine Tablets (Sarafem):
  - 1 tablet per day

- Fluvoxamine ER:
  - 2 tablets per day

- Fluoxetine weekly:
  - 1 pack per 28 days

Last Review: 1/2019
Previous PARP Approval: 6/2018
Current PARP Approval: 3/2019

Proprietary
Brisdelle:
1 tablet per day

Venlafaxine SR Tablets:
37.5mg, 75mg, and 225mg: 1 tablet per day
150mg: 2 tablets per day

Nefazodone:
2 tablets/day; up to 600mg max daily dose

**Medically Necessary** — A service or benefit is Medically Necessary if it is compensable under the MA Program and if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.

- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- The service or benefit will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member’s family/caretaker and the Primary Care Practitioner, as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under this Agreement.
References:


