

## Pharmacy Policy

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# Step Therapy – Antidepressant and Antipsychotic Agents

**Policy Number:** 9.506

**Version Number:** 2

**Version Effective Date:** 6/1/2021

Product Applicability <input type="checkbox"/> All Plan <sup>+</sup> Products	
<b>Well Sense Health Plan</b>	<b>Boston Medical Center Healthnet Plan</b>
<input type="checkbox"/> New Hampshire Medicaid	<input checked="" type="checkbox"/> Masshealth - MCO
	<input checked="" type="checkbox"/> Masshealth - ACO
	<input type="checkbox"/> Qualified Health Plans
	<input type="checkbox"/> Senior Care Options

Note: Disclaimer And Audit Information Is Located At The End Of This Document.

## Prior Authorization Policy

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### **POLICY STATEMENT:**

A step therapy program has been developed to encourage the use of generic Step-1 products prior to the use of a Step-2 product, without interrupting existing therapy. If the step therapy rule is not met for a Step-2 agent at the point of service, coverage will be determined by the step therapy criteria below. All approvals are provided for 1 year in duration.

### **Standard Criteria:**

The plan may authorize coverage of the products in the appendix for all FDA approved indications not otherwise excluded and for members meeting the following criteria when step therapy is not met at point of sale from claims history.

1. Prescribers must provide documentation (including dates of trial and outcome) that the member has tried and failed the appropriate number of Step 1 agents as indicated in Appendix A and in the coverage criteria requirements **OR**

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2. Prescriber must provide documentation that the member has a contraindication to or other clinical rationale preventing the use of ALL Step 1 agents indicated in Appendix A.

**Appendix A: Step Therapy Details**

<b>Antidepressants - Fluvoxamine</b>	
Evidence Of At Least One Paid Claim Of Fluvoxamine IR And One Other Step 1 Products in the Previous 130 days	
<b>Step 1</b>	<b>Step 2</b>
Bupropion IR/ER/XL ER Tablet Citalopram Tablet Duloxetine Capsule Fluoxetine Capsule Fluvoxamine IR Tablet Paroxetine IR/ ER Tablet Sertraline Tablet Venlafaxine IR tablet/ER Capsule	Fluvoxamine ER capsule

<b>Antidepressants- Desvenlafaxine</b>	
Evidence Of At Least One Paid Claim Of Venlafaxine And One Other Covered Step 1 Antidepressant In The Previous 130 Days	
<b>Step 1</b>	<b>Step 2</b>
Bupropion IR/ER/XL Tablet Citalopram Tablet Duloxetine Capsule Fluoxetine Capsule Fluvoxamine IR Tablet Paroxetine IR/ ER Tablet Sertraline Tablet Venlafaxine IR tablet /ER capsule	Desvenlafaxine ER tablet

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### Antidepressants – Misc.

Pharmacy claims indicating a trial of two Step 1 Agents in The Previous 130 Days

Step 1	Step 2
Bupropion IR/ER/XL ER Tablet Citalopram Tablet Tablet Duloxetine Capsule Fluoxetine Capsule Fluvoxamine IR Tablet Paroxetine IR/ ER Tablet Sertraline Tablet Venlafaxine IR tablet/ER Capsule	Fetzima Capsule Viibryd Tablet Trintellix Tablet

### Quetiapine

Pharmacy Claims Indicating The Use of IR product in the previous 130 days

Step 1	Step 2
QUetiapine Fumarate IR Tablet	QUetiapine Fumarate ER Tablet

### Olanzapine ODT

Pharmacy Claims Indicating The Use of IR product in the previous 130 days

Step 1	Step 2
Olanzapine IR Tablet	Olanzapine ODT Tablet

Original Approval Date	Original Effective Date	Policy Owner	Approved By
12/10/2020	1/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

### Policy Revisions History

Review Date	Summary Of Revisions	Revision Effective Date	Approved By
12/10/2020	Created separate policies per applicable line of business. Coverage duration changed to 1 year. Addition of policy statement and standard criteria. Changed	1/1/2021	Pharmacy & Therapeutics (P&T) Committee

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## Policy Revisions History

	trial look back to 130 days from 120 days.Changed trial look back to 130 days from 120 days.		
2/11/2021	Annual policy review, minor language changes to step therapy standard criteria	6/1/2021	P&T Committee

## Next Review Date

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2/2022

## Other Applicable Policies

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## Reference To Applicable Laws And Regulations, If Any

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### Disclaimer Information

Medical Policies Are the Plan's Guidelines For Determining The Medical Necessity Of Certain Services Or Supplies For Purposes Of Determining Coverage. These Policies May Also Describe When A Service Or Supply Is Considered Experimental Or Investigational, Or Cosmetic. In Making Coverage Decisions, The Plan Uses These Guidelines And Other Plan Policies, As Well As The Member's Benefit Document, And When Appropriate, Coordinates With The Member's Health Care Providers To Consider The Individual Member's Health Care Needs.

Plan Policies Are Developed In Accordance With Applicable State And Federal Laws And Regulations, And Accrediting Organization Standards (Including NCQA). Medical Policies Are Also Developed, As Appropriate, With Consideration Of The Medical Necessity Definitions In Various Plan Products, Review Of Current Literature, Consultation With Practicing Providers In The Plan's Service Area Who Are Medical Experts In The Particular Field, And Adherence To FDA And Other Government Agency Policies. Applicable State Or Federal Mandates, As Well As The Member's Benefit Document, Take Precedence Over These Guidelines. Policies Are Reviewed And Updated On An Annual Basis, Or More Frequently As Needed. Treating Providers Are Solely Responsible For The Medical Advice And Treatment Of Members.

The Use Of This Policy Is Neither A Guarantee Of Payment Nor A Final Prediction Of How A Specific Claim(S) Will Be Adjudicated. Reimbursement Is Based On Many Factors, Including Member Eligibility And Benefits On The Date Of Service; Medical Necessity; Utilization Management Guidelines (When Applicable); Coordination Of Benefits; Adherence With Applicable Plan Policies And Procedures; Clinical Coding Criteria; Claim Editing Logic; And The Applicable Plan – Provider Agreement.

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