BOSTON MEDICAL CENTER HEALTHNet PLAN

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Pharmacy Policy

Step Therapy - Anti-Depressant / Anti-Psychotic Agents

Policy Number: 9.506
Version Number: 2
Version Effective Date: 6/1/2021

Product Applicability	☐ **All Plan[+] Products**
Well Sense Health Plan ☐ New Hampshire Medicaid	**Boston Medical Center HealthNet Plan** ☐ MassHealth - MCO ☐ MassHealth - ACO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Prior Authorization Policy

POLICY STATEMENT:
A step therapy program has been developed to encourage the use of 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 failedthe appropriate number of Step 1 agents as indicated in Appendix A and in the coverage criteria requirements **OR**

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

Anti-Depressants		
Step 1	**Step 2**	**Coverage Criteria**
Bupropion IR/SR/XL Citalopram Duloxetine Escitalopram Fluoxetine* Fluvoxamine Paroxetine IR/ ER Sertraline Venlafaxine IR/ER	Desvenlafaxine ER Emsam Fetzima Trintellix Viibryd	A Step 2 medication will be covered when there are pharmacy claims indicating the previous use of **TWO** Step 1 agents in the previous 180 days

Atypical Antipsychotics - Quetiapine		
Step 1	**Step 2**	**Coverage Criteria**
QUEtiapine Fumarate IR Tablet	QUEtiapine Fumarate ER Tablet	A Step 2 medication will be covered when there are pharmacy claims indicating the previous use of the Step 1 agent in the previous 130 days

Atypical Antipsychotics - Olanzapine/Fluoxetine		
Step 1	**Step 2**	**Coverage Criteria**
Clozapine Tablet Risperidone Tablet Olanzapine Tablet Quetiapine Tablet Ziprasidone Tablet	OLANZapine-FLUoxetine	A Step 2 medication will be covered when there are pharmacy claims indicating the previous use of **ONE** Step 1 agent **AND** fluoxetine in the previous 130 days

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

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
9/10/2020	P&T Committee Review.9.087 Step Therapy Policy retired, new policy created. Updated policy to align with 2021 formulary. Changed approval duration from 2 to 1 year. Changed trial duration from 120 to 130 days.	1/1/2021	P&T Committee
2/11/2021	Annual policy review, minor language changes to step therapy standard criteria	6/1/2021	P&T Committee

Next Review Date

2/2022

Other Applicable Policies

Reference to Applicable Laws and Regulations, If Any

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.