Prior Authorization Guidelines
Brand Name Antipsychotic Augmentation of Antidepressant Therapy

Approved Indications:
Treatment Resistant Major Depression; Bipolar Disorder, Depression

Special Considerations:
This Prior Authorization guideline only applies to the addition of an antipsychotic to an antidepressant when the addition is to achieve augmentation of the antidepressant response. Approval is not needed when an antidepressant is added to the ongoing antipsychotic regimen when the antipsychotic is being used to manage a psychotic spectrum disorder. The antipsychotic requested must have an FDA approval for the specific depression indication.

Guidelines for Approval:
1. The member must have either a diagnosis of Major Depressive Disorder or Bipolar Disorder with an episode of depression.
2. The member must have demonstrated at least partial response to the primary antidepressant.
3. Evidence of trials of at least two (2) individual formulary evidence based augmentation strategies at accepted effective doses for a minimum trial of 2 weeks and failed, or the trials resulted in significant side effects, or other augmentation agents are contraindicated. Failure is due to:
   a. An inadequate response at maximum tolerated doses,
   b. Adverse reaction(s), or
   c. Break through symptoms.

Additional Requirements:
Provider must provide supporting documentation that adherence to the treatment regimen is not a contributing factor to the inadequate response to the medication trials.

Coverage is Not Authorized for:
1. Members with known hypersensitivity to the requested agent(s).
2. Members not meeting the above stated criteria.

References:
1. ADHS/DBHS: Provider Manual Section 3.15: Psychotropic Medication: Prescribing and Monitoring
3. Sequenced Treatment Alternatives to Relieve Depression (STAR*D) Study

Finalized: 8/5/2013