PRIOR AUTHORIZATION GUIDELINE
STEP THERAPY GUIDELINE

DEPARTMENT: Pharmacy	**DOCUMENT NAME:** vortioxetine (Trintellix)
PAGE: 1 of 2	**REFERENCE NUMBER:** NH.PMN.127
EFFECTIVE DATE: 02/14	**REPLACES DOCUMENT:**
RETIRED:	**REVIEWED:** 02/14, 05/16, 03/17, 07/18
PRODUCT TYPE: Medicaid	**REVISED:** 08/15, 7/17

IMPORTANT REMINDER

This Clinical Policy has been developed by appropriately experienced and licensed health care professionals based on a thorough review and consideration of generally accepted standards of medical practice, peer-reviewed medical literature, government agency/program approval status, and other indicia of medical necessity.

The purpose of this Clinical Policy is to provide a guide to medical necessity. Benefit determinations should be based in all cases on the applicable contract provisions governing plan benefits ("Benefit Plan Contract") and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between this Clinical Policy and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies are intended to be reflective of current scientific research and clinical thinking. This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding results. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members.

Description: Vortioxetine HBr is indicated for major depressive disorder. American Psychiatric Association clinical guideline recommends Selective Serotonin Reuptake Inhibitors (SSRI), Serotonin Norepinephrine Reuptake Inhibitors, Mirtazapine or bupropion as first-line therapies for major depressive disorder.

Brand: vortioxetine HBr (Trintellix®)

FDA Labeled Indications: For the treatment of mood disorders including, but not limited to Major Depressive Disorder

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Criteria for Approval:

A. Documented treatment failure of two PDL alternative agents or contraindications to their use.

Approval: Initial Approval: 12 months.
Continued Approval: 12 months.

References: 1. Clinical Pharmacology, on-line. Drug monographs. 1/2014.

Revision Log

Removed Hepatic and Renal impairment and provider type. Changed to treatment failure with 2 PDL agents or contraindication. Added "For treatment of Mood disorders including but not limited to"	08/15
Annual Review, No Changes	05/16
Annual Review, No Changes	03/17
Removed age restriction as age is not an absolute contraindication. Changed name of policy to Trintellix due to FDA name change.	07/17
Annual Review, No Changes	07/18

POLICY AND PROCEDURE APPROVAL

Pharmacy & Therapeutics Committee: Approval on file

V.P., Pharmacy Operations: Approval on file

Sr. V.P., Chief Medical Officer: Approval on file