DEPRESSION: PHC Treatment Flow Diagram for Formulary Compliance

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ADULT WITH DEPRESSION (non-psychotic)

Mild to Moderate

Severe

PHC Note on Antidepressants[4]:
There is a lack of evidence showing significant benefit *vs* placebo except in severe depression. Therefore, use PHQ9>14 as an indicator of severity and suggested threshold for treatment initiation, with goal of therapy PHQ9<5, or 10 when some points are attributable to other condition(s)

ABSENCE of risks for: Cardiovascular issues, Seizures, CYP40 interactions?

No

Prescriber selects agent which has acceptable risk:benefit ratio.

Yes

Min 6-12 wk (6 if no response, 12 if partial response) trial, max. dosing of Formulary First Line Agent: duloxetine, desvenlafaxine, citalopram, escitalopram, fluoxetine, paroxetine, sertraline, venlafaxine XR or bupropion SR

Formulary agent is appropriate for member

Formulary agents are not appropriate

Submit TAR with patient-specific contraindications or interactions

If pharmacotherapy *is* appropriate

Consider referral to a therapist for help and possible further assessment for appropriateness of medication

Pharmacotherapy is *not* appropriate

Continue cognitive behavioral therapy or other non-pharmacologic therapy.

Remission?

No

Progress through treatment levels per STAR-D study w/ 6-12wk min. trials, maximized dosing, adjunctive tx & CBT (cognitive behavioral therapy) as appropriate & available. (Double-click for STAR-D tx flow),

Remission?

No

T/F 4 treatment levels such as: SSRI, SNRI, TCA, Mirtazapine, Bupropion SR, MAO-I (carved-out to State), alone &/or in combination; also adjunctive tx: CBT, Li, T3; consideration of aripiprazole/ Abilify[1, 9, 11] (carved-out to State)

MULTI-DRUG RESISTANCE IS EVIDENT:
(1) Psychiatric Consult required for re-evaluation of diagnosis. (2) Psychiatrist may progress to non-formulary alternatives after confirmation of diagnosis & PHQ9 > 14 (3) Specialist to consider ETC or experimental therapy if PHQ9 > 20. (4) Non-formulary alternatives available to non-psychiatrist if psychiatrist is not available for consult & PHQ9 >20.

Yes

Continue treatment

Non-Formulary Antidepressants:

Fluoxetine 90 mg (Prozac Weekly)	Trazodone 300mg (Desyrel)
Fluoxetine tablets (Sarafem)	Desvenlafaxine (Khedezla ER)
Paroxetine CR (Paxil CR)	Vilazodone (Viibryd)
Clomipramine (Anafranil)	Vortioxetine (Trintellix)

Carve-Out drugs, submit to State Medi-Cal:

Atypical Antipsychotics (Ability, Risperdal, etc)	Selegiline patch (Emsam)
Phenelzine (Nardil)	Tranylcypromine (Parnate)

Formulary Alternatives are listed on page 3

Treatment Algorithm based on STAR*D prospective trial, through 4 treatment changes[3]

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Pt w/ non-psychotic depression, no bipolar d/o, no OCD, no eating d/o, no seizure d/o, no CYP interaction considerations, no cardiovascular dx.

Formulary First Line Agent: duloxetine, desvenlafaxine, citalopram, fluoxetine, paroxetine, sertraline, escitalopram, venlafaxine XR, mirtazapine or bupropion SR/XL

Following min. 8 wk trial @ max tolerated dosing

Remission Achieved?

No → (1) Change Rx to alternative formulary agent
--OR--
(2) continue same Rx & augment with a 2nd Rx (eg, bupropion SR/XL or buspirone added to SSRI) &/or CBT.

Following min. 8 wk trial, @ max tolerated dosing

Remission achieved?

No → △ Tx: alternative formulary agent TCA, or use augmenting agent (T-3, Lithium) [PHC: encourage psychiatric referral]

Following min. 8 wk trial, @ max tolerated dosing

Remission achieved?

No → △ Tx: Tranylcypromine* or Mirtazapine + Venlafaxine

Following min. 8 wk trial, @ max tolerated dosing

Remission achieved?

No → Multi-drug tx-resistance:

No specific STAR*D recommendations after 4 treatment failures....refer to PHC F/NF Decision Tree.

(double-click to return to previous flow)

Yes → Continue treatment

STAR*D Study Inclusion Criteria:

- Age 18-75
- Non-psychotic major depression
- Score >/= 14 on Hamilton Rating Scale for Depression
- None of the following: bipolar d/o, OCD, eating d/o, seizure d/o

Note regarding adequate trial durations:
STAR-D recommends a minimum 8 wk trial once pt is at max tolerated dose. PHC Subcommittee recommends that 6 wk is adequate to determine failure if no response present; if partial response, should continue tx x 12 wks before considering changing.

PHC Formulary Antidepressants

TCAs

Formulary, no restrictions:

- Amitriptyline (Elavil)
- Desipramine (Norpramin)
- Doxepin (Sinequan)
- Imipramine HCL (Tofranil only, not pamoate/PM)
- Nortriptyline (Pamelor)
- Protriptyline (Vivactil)

SSRIs

Formulary, no restrictions:

- Citalopram
- Escitalopram
- Fluoxetine
- Paroxetine
- Sertraline
- Fluvoxamine

SNRIs

Formulary, no restrictions:

- Venlafaxine ER ***capsules*** (generic Effexor XR)
- Venlafaxine IR tablets (generic Effexor)

Formulary, with restrictions:

- Desvenlafaxine Succinate ER (generic for Pristiq) – Limited to 1 per day
- Duloxetine – limited to 2 per day

OTHER

Formulary, no restrictions:

- Trazodone 50, 100 & 150mg (Generic Desyrel, immediate release)

Formulary, with restrictions:

- Bupropion, immediate release, limited to 3 per day (TID dosing)
- Bupropion SR, limited to 2 per day (BID dosing)
- Bupropion XR, limited to 1 per day (QD dosing)
- Mirtazapine, limited to 1 per day
- Nefazodone, limited to ages 18 and older

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