Clinical Policy: Vilazodone (Viibryd)
Reference Number: CP.PMN.145
Effective Date: 08.01.12
Last Review Date: 08.20
Line of Business: HIM, Medicaid

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Vilazodone (Viibryd®) is an antidepressant.

FDA Approved Indication(s)
Viibryd is indicated for the treatment of major depressive disorder.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Viibryd is medically necessary when the following criteria are met:

I. Initial Approval Criteria
   A. Depression (must meet all):
      1. Diagnosis of major depressive disorder;
      2. Age ≥ 18 years;
      3. Failure of a ≥ 8 week trial of one SSRI at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
      4. Failure of a ≥ 8 week trial of one SNRI at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
      5. Dose does not exceed 40 mg (1 tablet) per day.
   Approval duration: 12 months

   B. Other diagnoses/indications
      1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

II. Continued Therapy
   A. Depression (must meet all):
      1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
      2. Member is responding positively to therapy;
      3. If request is for a dose increase, new dose does not exceed 40 mg (1 tablet) per day.
   Approval duration: 12 months
B. Other diagnoses/indications (must meet 1 or 2):
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:
A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – HIM.PHAR.21 for health insurance marketplace and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
FDA: Food and Drug Administration
MAOI: monoamine oxidase inhibitor
SSRI: selective serotonin reuptake inhibitor
SNRI: serotonin norepinephrine reuptake inhibitor

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

<table>
<thead>
<tr>
<th>Drug Name</th>
<th>Dosing Regimen</th>
<th>Dose Limit/Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>citalopram (Celexa®)</td>
<td>20 mg PO QD; may increase to 40 mg PO QD after one week</td>
<td>40 mg/day (≤ 60 years) 20 mg/day (&gt; 60 years)</td>
</tr>
<tr>
<td>escitalopram (Lexapro®)</td>
<td>10 mg PO QD; may increase to 20 mg PO QD after 1 week</td>
<td>20 mg/day</td>
</tr>
<tr>
<td>fluoxetine (Prozac®, Prozac Weekly®)</td>
<td>Prozac: 20 mg PO QD; may increase by 10-20 mg after several weeks Prozac Weekly: 90 mg PO q week beginning 7 days after the last daily dose</td>
<td>Prozac: 80 mg/day Prozac Weekly: 90 mg/week</td>
</tr>
<tr>
<td>paroxetine (Paxil®, Paxil CR®, Pexeva®)</td>
<td>Paxil, Pexeva: 20 mg PO QD; may increase by 10 mg every week as needed Paxil CR: 25 mg PO QD; may increase by 12.5 mg every week as needed</td>
<td>Paxil, Pexeva: 60 mg/day (≤ 60 years) 40 mg/day (&gt; 60 years) Paxil CR: 75 mg/day (≤ 60 years) 50 mg/day (&gt; 60 years)</td>
</tr>
</tbody>
</table>
## Drug Name | Dosing Regimen | Dose Limit/Maximum Dose
--- | --- | ---
sertraline (Zoloft®) | 50 mg PO QD; may increase every week as needed | 200 mg/day

### SNRIs

duloxetine (Cymbalta®) | 20 mg PO BID or 30 mg PO BID or 60 mg PO QD | 120 mg/day

venlafaxine (Effexor®, Effexor XR®) | Effexor: 75 mg/day PO in 2-3 divided doses; may increase by 75 mg every 4 days as needed | Effexor: 225 mg/day (outpatient) or 375 mg/day (inpatient)

Effexor XR: 75 mg PO QD; may increase by 75 mg every 4 days as needed | Effexor XR: 225 mg/day |

desvenlafaxine (Pristiq®, Khedezla®) | 50 mg PO QD | 400 mg/day

Fetzima® (levomilnacipran) | 20 mg PO QD for 2 days, then 40 mg PO QD; may increase by 40 mg every 2 days | 120 mg/day

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

### Appendix C: Contraindications / Boxed Warnings
- Contraindication(s): Concomitant use of monoamine oxidase inhibitors (MAOIs), or use within 14 days of stopping MAOIs because of an increased risk of serotonin syndrome.
- Boxed warning(s): suicidal thoughts and behaviors in patients aged 24 years and younger. Closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. Viibryd is not approved for use in pediatric patients.

### V. Dosage and Administration

<table>
<thead>
<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Major depressive disorder</td>
<td>10 mg orally daily for 7 days, followed by 20 mg once daily</td>
<td>40 mg per day</td>
</tr>
</tbody>
</table>

### VI. Product Availability

Tablet: 10 mg, 20 mg, 40 mg

### VII. References
<table>
<thead>
<tr>
<th>Reviews, Revisions, and Approvals</th>
<th>Date</th>
<th>P&amp;T Approval Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Updated reference to reflect current literature search; Added age criteria for Viibryd since only FDA approved for adult use; Modified Background section to include details of mechanism of action; Updated initial criteria to include appropriate screening of drug to drug integration with MAOI therapy due to absolute contraindication with Viibryd; Updated renewal criteria to include bullet point #A.</td>
<td>02.16</td>
<td>05.16</td>
</tr>
<tr>
<td>Modified criteria to require the use of generic trials of 1 SSRIs and 1 SNRIs; removed MAOI safety information; updated references.</td>
<td>07.16</td>
<td>08.16</td>
</tr>
<tr>
<td>Removed age requirement, as age is not an absolute contraindication. Updated references.</td>
<td>03.17</td>
<td>08.17</td>
</tr>
<tr>
<td>3Q 2018 annual review: policies combined for Medicaid (CP.PPA.16) and HIM (HIM.PA.135) lines of business; no significant changes; Medicaid: added age; references reviewed and updated.</td>
<td>04.11.18</td>
<td>08.18</td>
</tr>
<tr>
<td>3Q 2019 annual review: no significant changes; added contraindications and boxed warnings; references reviewed and updated.</td>
<td>06.03.19</td>
<td>08.19</td>
</tr>
<tr>
<td>3Q 2020 annual review: no significant changes; references reviewed and updated.</td>
<td>05.06.20</td>
<td>08.20</td>
</tr>
</tbody>
</table>

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.
This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. 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. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:

For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.