Clinical Policy: Vortioxetine (Trintellix)
Reference Number: CP.PMN.65
Effective Date: 05.01.15
Last Review Date: 08.19
Line of Business: HIM, Medicaid

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

Description
Vortioxetine (Trintellix®) is an antidepressant

FDA Approved Indication(s)
Trintellix 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 Trintellix 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 20 mg/day (1 tablet/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 20 mg/day (1 tablet/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: 50 mg/day Paxil CR: 62.5 mg/day</td>
</tr>
<tr>
<td>sertraline (Zoloft®)</td>
<td>50 mg PO QD; may increase every week as needed</td>
<td>200 mg/day</td>
</tr>
</tbody>
</table>
## Vortioxetine

<table>
<thead>
<tr>
<th>Drug Name</th>
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<tbody>
<tr>
<td>SNRI</td>
<td></td>
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<tr>
<td>duloxetine (Cymbalta®)</td>
<td>20 mg PO BID or 30 mg PO BID or 60 mg PO QD</td>
<td>120 mg/day</td>
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<tr>
<td>venlafaxine (Effexor®, Effexor XR®)</td>
<td>Effexor: 75 mg/day PO in 2-3 divided doses; may increase by 75 mg every 4 days as needed Effexor XR: 75 mg PO QD; may increase by 75 mg every 4 days as needed</td>
<td>Effexor: 225 mg/day (outpatient) or 375 mg/day (inpatient) Effexor XR: 225 mg/day</td>
</tr>
<tr>
<td>desvenlafaxine (Pristiq®, Khedezla®)</td>
<td>50 mg PO QD</td>
<td>400 mg/day</td>
</tr>
<tr>
<td>Fetzima® (levomilnacipran)</td>
<td>20 mg PO QD for 2 days, then 40 mg PO QD; may increase by 40 mg every 2 days</td>
<td>120 mg/day</td>
</tr>
</tbody>
</table>

*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
- **Contraindication(s):** Hypersensitivity to vortioxetine or any components of the cortioxetine formulation. The use of MAOIs intended to treat psychiatric disorders within 21 days of stopping treatment with vortioxetine due to increased risk of serotonin syndrome. Use of trintellix within 14 days of stopping an MAOI. Do not start vortioxetine in a patient who is being treated with linezolid or intravenous methylene blue.
- **Boxed warning(s):** suicidal thoughts and behavior in children, adolescents, and young adults under age 24. Vortioxetine has not been evaluated for use in pediatric patients.

### V. Dosage and Administration

<table>
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<tr>
<th>Indication</th>
<th>Dosing Regimen</th>
<th>Maximum Dose</th>
</tr>
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<tbody>
<tr>
<td>Major depressive disorder</td>
<td>10 mg orally daily then increased to 20 mg/day as tolerated</td>
<td>20 mg/day</td>
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</table>

### VI. Product Availability

Immediate release tablet: 5 mg, 10 mg, 20 mg

### VII. References

**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.

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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.

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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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.

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