Texas Medicaid

Major Depressive Disorder (MDD) Management

Educational RetroDUR Mailing	❑Initial Study ☑Follow-up /Restudy

Executive Summary

Purpose:	To assist physicians in the optimization of antidepressant therapy. The American Psychological Association (APA) Guideline for the Treatment of Depression and the VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder provide the foundation for this proposal.[1,2] These guidelines, along with recently published major studies, provide performance indicators to reduce the variation in the use of antidepressants, maximize therapeutic benefits, and reduce adverse events associated with antidepressant use.		
Why Issue was Selected:	Major depression, or major depressive disorder (MDD), is one of the most common mood disorders among young and middle-aged adults. A 2014 report by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 6.7% of all U.S. adults had at least one major depressive episode within the past year.[1] First-line treatment for MDD is usually an antidepressant medication and often prescribed by a patient's primary care physician.[3] Comparison of current treatment practices to recommended guidelines may reduce variability in quality of care and result in improved outcomes with decreased costs.		
Program Specific Information:	**Performance Indicators**	**Exceptions**	
		(<18 Years) FFS	**(<18 Years) MCO**
	1. Medications for Depression Less than Six Months	(28) 230	(1617) 5560
	2. Medications for Depression Longer than Twelve Months for Single Episode Depression	(6) 43	(849) 3408
	3. Antidepressants in Children and Adolescents (*excluding fluoxetine ages 8-18 years & escitalopram ages 12-17 years)	(42) 42	(3648) 3648
	4. Duplicate Antidepressant Therapy	(0) 0	(5) 137

	5. Antidepressant Adherence	(16) 191	(3502) 11485
	6. Antidepressant Dose Consolidation	(0) 5	(96) 554
	7. Drug-Induced Depression	(8) 32	(609) 5022
Setting & Population:	All patients with drug therapy for antidepressant medications in the last 30 to 180 days. For some indicators a documented diagnosis of depression will also be required.		
Types of Intervention:	Cover letter and modified individual patient profiles		
Main Outcome Measures:	The results of this intervention will be measured when six months of post-initiative data are available.		
Anticipated Results:	Increased awareness of the latest clinical practice guidelines regarding antidepressants may positively influence antidepressant prescribing practices. Specifically, physician re-examination of antidepressant use as a result of this mailing may reduce the unnecessary use of duplicate therapy, optimize duration of therapy, improve adherence, and decrease the occurrence of adverse outcomes.		

Performance Indicator #1: Medications for Depression Less than Six Months

Why has this indicator been selected?	The goal of acute phase treatment of depression, typically the first 6 to 12 weeks of treatment is remission of symptoms and improvement in quality of life. After achieving remission, a continuation phase of treatment is recommended to preserve remission and prevent relapse. The VA/DoD guidelines recommend continuation of the antidepressant at therapeutic dose for at least 6 months to decrease the risk of relapse. This indicator will target depressed patients with less than six months of continuous antidepressant therapy.[2]
Candidates (denominator):	All patients with a diagnosis of depression in the past 2 years and antidepressant therapy in the past 180 days
Exception criteria (numerator):	Candidates who were newly started on an antidepressant in the past 180 days but have no antidepressant therapy in the most recent 30 days.

Performance Indicator #2: Medications for Depression Longer than Twelve Months for Single Episode Depression

Why has this indicator been selected?	Depression may be a chronic, recurring illness, but many individuals will have a single episode. After an individual with an initial, single depressive episode has achieved remission and completed the continuation phase of treatment, meta-analysis concluded longer duration of treatment (9 or 12 months) did not provide additional benefit. Therefore, the need for maintenance antidepressant therapy should be assessed.[2]
Candidates (denominator):	All patients with a diagnosis of depression, single episode in the past 2 years receiving antidepressant therapy in the past 30 days.
Exception criteria (numerator):	Candidates with more than 12 months of antidepressant therapy for diagnosis of depression, single episode.

Performance Indicator #3: Antidepressants in Children and Adolescents

Why has this indicator been selected?	Only two second generation antidepressants (escitalopram and fluoxetine) are FDA-approved for use in children and adolescents for depression.[4] Other agents may be effective in select patients but have not been adequately studied in this population to establish approval. There are still others that have been studied and have not proven to be more effective than placebo. All antidepressants have a boxed warning related to their use in young people and the risk of suicide. Discontinuation of a medication that is effective in a given individual is not encouraged. However, when starting new young people on antidepressants, consideration of an FDA-approved medications is recommended.
Candidates (denominator):	Patients < 18 years of age, current therapy with an antidepressant in the last 45 days, and history of depression in the last 2 years.
Exception criteria (numerator):	History of current therapy with an antidepressant in the last 45 days. Patients with a history of fluoxetine ages 8-18 years and escitalopram ages 12-17 years are excluded. Patients on bupropion with a diagnosis in the last 2 years of ADD/ADHD or conduct disorders are also excluded.

Performance Indicator #4: Duplicate Antidepressant Therapy

Why has this indicator been selected?	Concurrent use of multiple antidepressants may occur for a number of reasons, both intended and unintended. Intended duplicate therapy may occur when a provider attempts to augment a partial response to the initial antidepressant by adding a second antidepressant instead of other adjunctive treatments like an atypical antipsychotic. Unintended duplicate therapy can result when there is a lack of coordination of care among multiple prescribers or patients misunderstand directions when changing therapy. Additive adverse effects and increased risk toxicity, especially involving the serotonin system, is possible when antidepressants with similar pharmacology are combined.[5,6]
Candidates (denominator):	All patients with history of antidepressant therapy in the most recent 90 days, and history of depression in the last 2 years.
Exception criteria (numerator):	Candidates taking more than one serotonergic antidepressant concomitantly for longer than 35 of the past 60 days. Trazodone is excluded at doses < 200 mg/day.

Performance Indicator #5: Antidepressant Adherence

Why has this indicator been selected?	Patients who are non-adherent with prescribed antidepressant regimens are more likely to experience relapse or recurrence, have more frequent emergency and hospital visits, as well as increased depression and suicidal ideation severity. [7]
Candidates (denominator):	All patients with a diagnosis of depression in the past 2 years receiving therapy with an antidepressant in the past 135 days.
Exception criteria (numerator):	Candidates who received < 60 days' supply of an antidepressant medication in a 90-day window will be deemed non-compliant. To eliminate from consideration patients who have stopped therapy and/or switched to another drug, patients who did not receive the implicated antidepressant in the 45-day periods before and after the 90-day window will be excluded from the analysis.

Performance Indicator #6: Antidepressant Dose Consolidation

Why has this indicator been selected?	Many antidepressants have a half-life that is long enough to allow for once a day dosing or are available in sustained-release dosage forms designed for once daily dosing. Using a single dosage unit given once a day whenever possible may improve compliance.[7]
Candidates (denominator):	All patients over 18 years of age with antidepressant therapy in the past 180 days that is appropriate for dose consolidation.
Exception criteria (numerator):	Candidates taking two dosage units per day of an identified antidepressant when a single dose per day of the same dosage is possible.

Performance Indicator #7: Drug-Induced Depression

Why has this indicator been selected?	Certain medications are known to either exacerbate depressive symptoms or actually induce a depressive disorder. Patients being treated with an antidepressant for depression should not be on such medications concomitantly unless absolutely necessary.[8-11]
Candidates (denominator):	All patients with a diagnosis of depression in the past 2 years receiving current therapy with an antidepressant in the past 45 days.
Exception criteria (numerator):	Candidates also receiving current therapy with a medication associated with causing depression in the past 45 days (see Table 1).

References:

1. APA Guidelines for the Treatment of Depression. American Psychological Association. February 16, 2019. Available at: https://www.apa.org/depression-guideline/guideline.pdf. Accessed November 2020.
2. VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder. Department of Veterans Affairs and Department of Defense. April 2016. Available at: https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf. Accessed November 2020.
3. Depression (major depressive disorder). Mayo Clinic. February 3, 2018. Available at: https://www.mayoclinic.org/diseases-conditions/depression/diagnosis-treatment/drc-20356013. Accessed: November 2020.
4. FDA Approved Drug Products: Drugs at FDA. Official Prescribing Information available by drug name. Available at: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction Accessed November 2020.
5. Monaco, Kristen. Clinical Challenges: Treatment Combinations for Depression. MedPage Today. October 17, 2019. Available at: https://www.medpagetoday.com/clinical-challenges/psych-congress-psych-drug-use/82786?vpass=1. Accessed November 2020.
6. Hoffelt, C, Gross, T. A review of significant pharmacokinetic drug interactions with antidepressants and their management. Mental Health Clinician (2016) 6 (1): 35–41. Available at: https://meridian.allenpress.com/mhc/article/6/1/35/128014/A-review-of-significant-pharmacokinetic-drug. Accessed: November 2020.
7. Martin-Vazquez, M. Adherence to antidepressants: A review of the literature. Neuropsychiatry (2016) Volume 6, Issue 5. Available at: https://www.jneuropsychiatry.org/peer-review/adherence-to-antidepressants-a-review-of-the-literature.html. Accessed: November 2020.
8. Pinto, E and Andrade, C. Interferon-Related Depression: A Primer on Mechanisms, Treatment, and Prevention of a Common Clinical Problem. Curr Neuropharmacol. 2016 Oct; 14(7): 743–748. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5050402/. Accessed: November 2020.
9. Zagaria, Mary Ann. Systemic Corticosteroids- Associated Psychiatric Adverse Events. U.S. Pharm. 2016:41(7):16-18. Available at: https://www.uspharmacist.com/article/systemic-corticosteroidassociated-psychiatric-adverse-effects. Accessed November 2020.
10. FDA Approved Drug Products: Drugs at FDA. Accutane. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/018662s060lbl.pdf. Accessed November 2020.
11. Tisdale, J and Miller, D. Drug-Induced Diseases 3rd Edition. Botts, S and Ryan, M. Drug-Induced Psychiatric Diseases, p.375-398. Available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/medications-suicidality/drug-induced-diseases.ashx?la=en&hash=A13BB8139724ECC96702217C4823B641234F93AB. Accessed: November 2020.

Table 1: Medications Implicated as Causing/Worsening Depression[8-11]

Corticosteroids
Interferons
Isotretinoin
Methyldopa
Propranolol
Reserpine

TEXAS
Health and Human Services

Cecile Erwin Young
Executive Commissioner

<<Date>>
«dea»
«name»
«add1»
«add2»
«add3»

RE: Major Depressive Disorder Management

Dear Dr. «name»:

Thank you for providing quality care for Texas Fee-For-Service (FFS) Medicaid patients. The content of this letter has been approved by the Texas Drug Utilization Review (DUR) Board, whose function is to promote safe and cost-effective drug therapy and provide opportunities for continuous improvement of care.

The goal of this retrospective claims review is to assist you in caring for your patients with major depressive disorder (MDD) and optimize their antidepressant therapy regimens. MDD is one of the most common mood disorders among youth and middle-aged adults. A 2014 report by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 6.7% of all U.S. adults had at least one major depressive episode within the past year.[1] First-line treatment for MDD is usually an antidepressant medication and they are often prescribed by a patient's primary care physician.[3] The American Psychological Association (APA) guideline for the treatment of depression, along with other current literature, provide the basis for the following parameters identified to help maximize antidepressant benefits.

APA Guideline for the Treatment of Depression: https://www.apa.org/depression-guideline/guideline.pdf.

Claims data indicate that in the Texas Medicaid FFS Program there are over 5,0000 individuals being treated for depression. This treatment included 7,509 prescriptions for antidepressants in a recent 90-day period at the total cost of $101,935. The total Texas Medicaid FFS performance indicators for patients less than 18 years of age with opportunities for this intervention are also shown in the table below.

Total Texas Medicaid FFS Specific Data

Major Depressive Disorder Management Indicator Summary	Number of Patients with Opportunities*	
	<18 Years	**≥18 Years**
Medications for Depression Less than Six Months	28	202
Medications for Depression Longer than Twelve Months for Single Episode Depression	6	37
Antidepressants in Children and Adolescents (*excluding fluoxetine ages 8-18 years & escitalopram ages 12-17 years)	42	N/A
Duplicate Antidepressant Therapy	0	0
Antidepressant Adherence	16	175
Antidepressant Dose Consolidation	0	5
Drug-Induced Depression	8	24

*Based on data through November 10, 2020

The enclosed patient profiles reflect one or more of the above issues and are provided as a medical record reminder for when your patients return for their next appointments.

We acknowledge that there may be clinical variables influencing an individual patient's management that are not apparent in claims data. However, we believe the issues identified may assist you in caring for your patient(s). It is possible that your license number may have been inadvertently assigned to the claim as an error at the pharmacy during the billing process. **Also, some prescribed medications as well as some recommended laboratory monitoring or physical examinations may not appear on the patient's profile because they may have been privately purchased or were not billable to Medicaid Services.** We thank you for reviewing this information and caring for Texas Medicaid patients, and we welcome the opportunity to discuss any comments or concerns you may have about our quality management program. Please feel free to call our office at 1-866-923-7208 with questions or concerns. If your mailing address is incorrect, it must be updated through the Texas Medical Board online at **http://www.tmb.state.tx.us/page/change-address.**

Sincerely,

Medicaid Drug Use Review Board
Vendor Drug Program H-630

Major Depressive Disorder Management Indicator Summary
• **Medications for Depression Less than Six Months** After achieving remission during the acute phase of treatment, a continuation phase of treatment is recommended to preserve remission and prevent relapse. The VA/DoD guidelines recommend continuation of the antidepressant at therapeutic dose for at least 6 months to decrease the risk of relapse. Cessation of therapy prior to six months may increase the chances of relapse.[2]
• **Medications for Depression Longer than Twelve Months for Single Episode Depression** Oftentimes, depression is a chronic illness, but many individuals will have a single episode. After achieving remission and completing continuation phase treatment, an individual with a single depressive episode should be assessed for the need for maintenance therapy.[2]
• **Encourage appropriate antidepressant use in children and adolescents**. Only two second generation antidepressants (escitalopram and fluoxetine) are FDA-approved for use in children and adolescents to treat depression. Some agents may be effective in select patients but have not been adequately studied in this population to establish approval; while others that have been studied have not proven to be more effective than placebo. All antidepressants have a boxed awrning related to their use in young people and the risk of suicide. We do not encourage discontinuation of a medication that is effective in a given individual but do encourage considering FDA-approved medications when starting new patients on antidepressants.[4]
• **Eliminate unintentional duplicate therapy with antidepressant medications.** Use of more than one antidepressant with serotonergic activity concurrently has not been proven to improve clinical outcomes. Additionally, additive adverse effects and increased risk of toxicity is possible when antidepressants with similar mechanisms of action are combined. Trazodone is excluded at doses < 200 mg/day.[5,6]
• **Improve adherence to antidepressant drug therapy in patients on maintenance antidepressant medications**. Patients who are adherent with their antidepressant treatment are less likely to experience a recurrence, utilize fewer healthcare resources, and are less likely to relapse.[7]
• **Improve adherence to antidepressant drug therapy by minimizing pill burden.** Many antidepressants have a half-life that is long enough to allow for once a day dosing or are available in sustained-release dosage forms designed for once daily dosing. Using a single dosage unit given once a day whenever possible may improve compliance.[7]

- **Eliminate medications that may induce and/or exacerbate depression in patients who have experienced depressive symptoms** (see Table 1). Certain medications are known to exacerbate depressive symptoms or induce a depressive disorder. Patients utilizing antidepressants for depression or depressive symptoms should be carefully evaluated for concomitant use of these medications and they should be avoided when possible.[8-11]

References:

1. APA Guidelines for the Treatment of Depression. American Psychological Association. February 16, 2019. Available at: https://www.apa.org/depression-guideline/guideline.pdf. Accessed November 2020.
2. VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder. Department of Veterans Affairs and Department of Defense. April 2016. Available at: https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf. Accessed November 2020.
3. Depression (major depressive disorder). Mayo Clinic. February 3, 2018. Available at: https://www.mayoclinic.org/diseases-conditions/depression/diagnosis-treatment/drc-20356013. Accessed: November 2020.
4. FDA Approved Drug Products: Drugs at FDA. Official Prescribing Information available by drug name. Available at: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/index.cfm?fuseaction Accessed November 2020.
5. Monaco, Kristen. Clinical Challenges: Treatment Combinations for Depression. MedPage Today. October 17, 2019. Available at: https://www.medpagetoday.com/clinical-challenges/psych-congress-psych-drug-use/82786?vpass=1. Accessed November 2020.
6. Hoffelt, C, Gross, T. A review of significant pharmacokinetic drug interactions with antidepressants and their management. Mental Health Clinician (2016) 6 (1): 35–41. Available at: https://meridian.allenpress.com/mhc/article/6/1/35/128014/A-review-of-significant-pharmacokinetic-drug. Accessed: November 2020.
7. Martin-Vazquez, M. Adherence to antidepressants: A review of the literature. Neuropsychiatry (2016) Volume 6, Issue 5. Available at: https://www.jneuropsychiatry.org/peer-review/adherence-to-antidepressants-a-review-of-the-literature.html. Accessed: November 2020.
8. Pinto, E and Andrade, C. Interferon-Related Depression: A Primer on Mechanisms, Treatment, and Prevention of a Common Clinical Problem. Curr Neuropharmacol. 2016 Oct; 14(7): 743–748. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5050402/. Accessed: November 2020.
9. Zagaria, Mary Ann. Systemic Corticosteroids- Associated Psychiatric Adverse Events. U.S. Pharm. 2016:41(7):16-18. Available at: https://www.uspharmacist.com/article/systemic-corticosteroidassociated-psychiatric-adverse-effects. Accessed November 2020.
10. FDA Approved Drug Products: Drugs at FDA. Accutane. Available at: https://www.accessdata.fda.gov/drugsatfda_docs/label/2010/018662s060lbl.pdf. Accessed November 2020.
11. Tisdale, J and Miller, D. Drug-Induced Diseases 3rd Edition. Botts, S and Ryan, M. Drug-Induced Psychiatric Diseases, p.375-398. Available at: https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/medications-suicidality/drug-induced-diseases.ashx?la=en&hash=A13BB8139724ECC96702217C4823B641234F93AB. Accessed: November 2020.

Table 1: Medications Implicated as Causing/Worsening Depression[8-11]

Corticosteroids
Interferons
Isotretinoin
Methyldopa
Propranolol
Reserpine

Messid	Internal	External
8303	Depression: Short Duration (<6 mo)	Potential Inadequate Course of Antidepressant Therapy: Based on pharmacy and medical claims, it appears that your patient has received an antidepressant for less than 6 months. Current treatment guidelines recommend that an episode of depression be treated for at least 6 months if not for an additional 6 months after achieving a remission of symptoms. Research indicates that many patients stop their antidepressants because "they are feeling better" or "it wasn't helping" or "it made me feel worse" without informing their provider. If this has happened, please discuss the need for a longer duration of treatment with your patient. If the discontinuation was intentional please monitor your patient for signs and symptoms of depression relapse.
8304	Depression: Long Duration (>12 mo) single episode	Potential Extended Duration of Antidepressant Without Recurrent Episodes of Depression: Based on pharmacy and medical claims, it appears that your patient has received an antidepressant for longer than 12 months. Current treatment guidelines recommend that the initial episode of depression be treated for approximately 6 months after achieving a remission of symptoms. Generally around the one year mark patients are considered to be entering the maintenance phase of treatment, a phase not all patients require. Decisions regarding maintenance treatment are generally based on residual symptoms, severity of symptoms, number of prior episodes, and patient preference. Please evaluate your patients therapy and consider if they are a candidate for discontinuing antidepressant therapy. If it is no longer needed the medication should be slowly tapered.
8324	Antidepressant Med: Non-Adherence w/treatment	It appears your patient may be non-adherent with their chronic antidepressant therapy. Based on submitted pharmacy claims data your patient received less than 60 days of medication in a recent 90 day period. If this was a joint decision please disregard this message. If your patient unilaterally decided to not take their medication it may be because of adverse effects or a lack of belief that the medication can really help. Please review this information and determine the best course of action for your patient.

8333	Drug-Induced Depression	Medications that Induce or Exacerbate Depression: Based on submitted pharmacy and medical claims, it appears your patient is concurrently being treated with an antidepressant and a medication that is known to induce and/or exacerbate depression. Such concurrent use is not advised as the agent indicated may inhibit the response to the antidepressant. In some cases, an antidepressant may not be needed at all if the interfering medication is discontinued. Please review your patients current therapy and consider discontinuing or changing the indicated medication that may be complicating the management of the depression.
8335	Duplicate Antidepressants	Duplicate Antidepressant Use: According to submitted pharmacy claims data, it appears your patient has received more than one antidepressant. Although use of a combination of antidepressants may be intentional, limited controlled data exist in the literature to support the efficacy of such combinations. Most available published data lack a control group and therefore cannot rule out that an extended period of time on one drug would have produced similar results. Additionally, multiple medications may result in increased adverse effects and decreased compliance. There is also concern as to whether your patient has informed you that other physicians may be prescribing similar medications. Please review the continued need for this therapy and consider discontinuation of or change in therapy if appropriate.
8336	Duplicate SSRI	Simultaneous Use of More Than One Selective Serotonin Reuptake Inhibitor (SSRI): Based on submitted pharmacy claims, it appears your patient has received more than one SSRI concurrently. Although use of this combination of antidepressants may be intentional, limited controlled data exist in the literature to support the efficacy of such combinations. Most available published data lack a control group and therefore cannot rule out that a more extended period of time on one drug would have produced similar results. There is also evidence that any single SSRI will saturate the serotonin reuptake pump. The pharmacological benefits of adding a second serotonin reuptake inhibitor would appear to be minimal. Conversely, adverse effects may be increased and compliance decreased. Please review the continued need for this therapy and consider discontinuation of or change in therapy if appropriate.

8337	SSRI + Other Serotonin Antidepressants	Simultaneous Use of a Selective Serotonin Reuptake Inhibitor (SSRI) with Another Serotonergic Antidepressant: According to submitted pharmacy claims data, it appears your patient has received an SSRI plus another serotonergic antidepressant concurrently. Although use of this combination of antidepressants may be intentional, limited controlled data exist in the literature to support the efficacy of such combinations. Most available published data lack a control group and therefore cannot rule out that a more extended period of time on one drug would have produced similar results.In addition, the use of multiple serotonergic medications carries with it a risk for the developmentof serotonin syndrome. Other adverse effects may also increase and compliance may decrease. Please review the continued need for this therapy and consider discontinuation of or change in therapy if appropriate.
8348	SSRI + TCA	Simultaneous Use of a Selective Serotonin Reuptake Inhibitor (SSRI) with a Tricyclic Antidepressant (TCA): According to submitted pharmacy claims data, it appears your patient has received an SSRI plus a TCA concurrently. Although use of this combination of antidepressants may be intentional, limited controlled data exist in the literature to support the efficacy of such combinations. Most available published data lack a control group and therefore cannot rule out that a more extended period of time on one drug would have produced similar results. In addition, many SSRIs inhibit the metabolism of TCAs and increase TCA levels. Such increased TCA levels may improve response in some, but have also been reported to produce toxic cardiac effects. Other adverse effects may also increase and compliance may decrease. Please review the continued need for this therapy and considerdiscontinuation of or change in therapy if appropriate.
8391	Dose Consolidation - Bupropion SR 24hr	Dose Consolidation - Bupropion HCl SR 24hr: According to submitted pharmacy claims data, your patient is currently receiving multiple dosage units per day and may be a candidate for dose consolidation of Wellbutrin XR® (bupropion HCl). This product is specially formulated for once daily administration without regard to meals. Its time to peak levels of over five hours makes morning administration desirable to avoid drug-induced insomnia. Common daily doses are available as single tablets and one tablet once a day generally results in the highest compliance rate as well as the lowest cost.
8392	Dose Consolidation - Mirtazapine	Dose Consolidation - Mirtazapine: According to submitted pharmacy claims data, your patient is currently receiving multiple dosage units per day and may be a candidate for dose consolidation of Remeron® (mirtazapine). Its half-life averages 30 hours and it should be administered once a day without regard to meals. Preferably, it should be taken as a single daily dose before going to bed. Common daily doses are available as single tablets and one tablet once a day generally results in the highest compliance rate as well as the lowest cost.

8393	Dose Consolidation - Venlafaxine	Dose Consolidation - Venlafaxine SR: According to submitted pharmacy claims data, your patient is currently receiving multiple dosage units per day and may be a candidate for dose consolidation of Effexor XR® (venlafaxine). This product is specially formulated for once daily administration with food either in the morning or the evening at approximately the same time each day. Common daily doses are available as single capsules and one capsule once a day generally results in the highest compliance rate as well as the lowest cost.
8394	Dose Consolidation - SSRI	Dose Consolidation - SSRI: According to submitted pharmacy claims data, your patient is currently receiving multiple dosage units per day and may be a candidate for dose consolidation of an SSRI. All SSRIs have half-lives long enough to be suitable for administration once a day. With the exception of fluvoxamine, they should preferably be taken as a single daily dose either in the morning or before going to bed. Common daily doses are available as single tablets and one tablet once a day generally results in the highest compliance rate as well as the lowest cost.
9122	Venlafaxine/Desvenlafaxine in Child/Adolescents with Depress	According to submitted pharmacy and medical claims your patient, who is <18 years of age, has received venlafaxine or desvenlafaxine for the treatment of depression. Venlafaxine or desvenlafaxine has not been shown to be effective for treating depression in children and adolescents, and may be associated with an increased risk of suicide compared to SSRIs. Fluoxetine and escitalopram are the only two SSRIs that have been proven effective in controlled clclinical studies of depression in youth and are the only SSRIs FDA approved for this indication. Other SSRIs have been the subject of failed published controlled trials and all antidepressants carry a risk of increased suiciada ideation in this age group. If you feel continued use of the current antidepressant is more appropriate, please monitor your patient for lack of beneficial effecand/or behavioral worsening, including suicidal ideation.
9123	Bupropion in Children & Adolescents with Depression	According to submitted pharmacy and medical claims your patient, who is <18 years of age, has received bupropion for the treatment of depression. Bupropion has not been shown to be effective for treating depression in children and adolescents in the absence of comorbid ADHD or conduct disorder. Fluoxetine and esitalopram are the only two SSRIs that have been proven effective in controlled clinical studies of depression in youth and are the only ones FDA approved for this indication. Other SSRIs have been the subject of failed published controlled trials and all antidepressants carry a risk of increased suicidal ideation in this age group. If you feel continued use of the current antidepressant is more appropriate, please monitor your patfor lack of beneficial effects and/or behavioral worsening, including suicidal ideation.

9128	Tricyclic Antideps (TCA) in Children & Adolescent/Depression	According to submitted pharmacy and medical claims your patient, who is <18 years of age, has received a tricyclic antidepressant. TCAs have not been shown to be effective for treating depression in children and adolescents and have been shown to have significant cardiovascular risks in youth. Fluoxetine and escitalopram are the only two SSRIs that have been proven to be effective in controlled clinical studies of depression in youth and are the only SSRIs FDA approved for this indication. All antidepressants carry a risk of increased suicidal ideation in this age group. If you feel continued use of the current antidepressant is more appropriate, please monitor your patient for lack of beneficial effects and/or behavioral worsening, as well as cardiac adverse effects.
9129	Misc. Antidepressants in Children & Adolescents w/Depression	According to submitted pharmacy and medical claims your patient, who is <18 years of age, has received the antidepressant indicated for the treatment of depression. This antidepressant has not been adequately studied for treating depression in children and adolescents. Fluoxetine and escitalopram are the only SSRIs that have been proven to be effective in controlled clinical studies of depression in youth and are the only SSRIs FDA approved for this indication. All antidepressants carry a risk of increased suicidial ideation in this age group. If you feel contiuned use of this antidepressant is more appropriate, please monitor your patient for lack of beneficial effects and/or behavioral worsening, including suicidal ideation.
11950	Dose Consolidation: Desvenlafaxine	Dose Consolidation - Desvenlafaxine: According to submitted pharmacy claims data, your patient is currently receiving multiple dosage units per day of Pristiq® (desvenlafaxine) and may be a candidate for dose consolidation. This product is specially formulated for once daily administration without regard to meals. Common daily doses are available as single tablets and one tablet once a day generally results in the highest compliance rate as well as the lowest cost.
11953	Dose Consolidation: Bupropion HBr	Dose Consolidation - Bupropion HBr: According to submitted pharmacy claims data, your patient is currently receiving multiple dosage units per day of Aplenzin (Bupropion HBr) and may be a candidate for dose consolidation. This product is specially formulated for once daily administration without regard to meals. Common daily doses are available as single tablets and one tablet once a day generally results in the highest compliance rate as well as the lowest cost.

102384	SSRIs in Children and Adolescents w Depression	SSRIs in Children and Adolescents with Depression: According to pharmacy and medical claims, your patient who is less than 18 years of age and has a diagnosis of depression is receiving an SSRI other than escitalopram or fluoxetine. Those two SSRIs are the only ones that have been proven effective in controlled clinical studies of depression in youth and are the only SSRIs FDA approved for this indication. Other SSRIs have been the subject of failed published controlled trials and all antidepressants carry a risk of increased suicidal ideation in this age group. It is important to consider the risk / benefit aspect of your patient's medications. If they are doing well on the current therapy there is no need to change. If not, please consider a change to either escitalopram or fluoxetine unless they have failed a previous trial of these agents.