



MAJOR DEPRESSION
CLINICAL PRACTICE GUIDELINE

Topic	Recommendations
Purpose	SummaCare Health Plan bases its Clinical Practice Guideline for Major Depressive Disorder in Adults on clinical guidelines established by the American Psychiatric Association and a review of current scientific literature. The purpose for the guideline is to ensure consistent and appropriate diagnosis, treatment, and referral for members with a Major Depressive Disorder (MDD), irrespective of the practice setting in which they access care.
Access	<p>Members may seek initial treatment for depression from their Primary Care Physician (PCP) or directly from a behavioral health specialist. SummaCare members may access care directly from behavioral health practitioners without a referral from their Primary Care Physician.</p> <p>Members will have access to behavioral health care according to the following standards:</p> <ul style="list-style-type: none"> ▪ A member with life-threatening emergency needs is seen immediately ▪ A member with non-life threatening emergency needs has access to care within 6 hours ▪ A member with urgent needs has access to care within 48 hours ▪ A member has access to a routine office visit within 10 working days ▪ A member discharged from the hospital for a mental health diagnosis will have a follow-up appointment within 7 days of discharge
Assessment	<p>The diagnosis of Major Depressive Disorder (MDD) is determined following a face-to-face clinical evaluation that is conducted by a Primary Care Physician (PCP) or behavioral health specialist.</p> <p>The practitioner conducting the assessment will carefully rule out medical disorders or use of medications that can mimic, mask, or potentiate symptoms associated with MDD.</p> <p>A thorough assessment for substance abuse and/or dependence are necessary to rule out a substance induced mood disorder.</p>
Diagnosis	<p>DSM-IV OR DSM-IV-PC criteria should be used to support the diagnosis of MDD. Accurate diagnosis is essential, as selection of effective treatment options is increasingly driven by a differential diagnosis for specific types of depression, such as Dysthymia, Seasonal Affective Disorder, and Substance Induced Mood Disorder.</p> <p>Family history and/or prior patient history for depression can further support the diagnosis.</p>

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	<p>The diagnosis should be comprehensive and include all five axes for DSM-IV.</p> <ul style="list-style-type: none"> ▪ Type and severity of depression should be specified using 5-digit coding ▪ Axis IV describes psychosocial stressors that may require psychotherapy and/or social intervention ▪ Axis III identifies co-existing medical conditions that necessitate coordination of care with the patient's PCP ▪ Use of Global Assessment of Function (GAF) score on Axis V clarifies the degree of current functional impairment in contrast to the highest function level in the past year
<p>Treatment and Referral</p>	<p>Discuss the diagnosis of Major Depression with the member and, as consented to, with his or her support system when appropriate. This discussion should include therapeutic goals and objectives and the treatment options available for achieving those goals and objectives.</p> <p>The patient should be apprised of treatment options, associated benefits and risks at the time treatment is initiated, and again when the patient is stable.</p> <p>Appropriate treatment considerations include:</p> <ul style="list-style-type: none"> ▪ Provision of safety and appropriate level of care ▪ Provision of treatment in the least intensive, clinically appropriate setting ▪ Regular monitoring for crises, decline in function, or other indications that may warrant a change in the level of care ▪ Initiation of medication based on severity of condition ▪ Initiation of psychotherapy based on psychosocial stressors identified on Axis IV. (Scientific literature supports concurrent treatment with psychotherapy and medication as more effective than treatment with medication alone.) ▪ Referral to a psychiatrist or the member's Primary Care Physician (PCP) for medication evaluation when a non-prescribing behavioral health practitioner makes the diagnosis ▪ Referral to the member's PCP as clinically warranted to rule-out potential medical disorders that may be mimicking, masking, or affecting symptoms ▪ When the diagnosis is made by a PCP, referral to a behavioral health specialist for psychotherapy when there are Axis IV stressors, and in the following situations is encouraged: <ul style="list-style-type: none"> • Uncertainty about the diagnosis • Possibility of organic brain disease or dementia • Failure to respond to treatment • Comorbidity with drugs or alcohol • Children or adolescents • Risk of suicide, homicide or other violence • Severe or complex presentations • The need for psychotherapy as adjunctive treatment to medications • Non-adherence to recommended advice or treatment • Clinical judgment warrants a need for greater resources

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	<ul style="list-style-type: none"> ▪ Patients with a diagnosis of Depression with Psychotic Features (fifth digit of 4) and MDD, Severe (fifth digit of 3) must be referred for an evaluation with a psychiatrist. ▪ Coordination of care between behavioral health practitioners when more than one specialist is involved in the care. (A therapist and a psychiatrist). ▪ Coordination of care between the member's behavioral health practitioner(s) and PCP.
Medication Management	<p>Suggested follow-up for persons whose treatment includes initiation of anti-depressant medication is recommended as follows:</p> <p><u>Acute Phase of Treatment (12 weeks)</u></p> <ul style="list-style-type: none"> ▪ Treatment with anti-depressant medication should be continuous during this time ▪ Monitor the patient closely for response to the medication and assess that he or she is taking the medication as prescribed ▪ Appropriate follow-up when an antidepressant medication is prescribed for a new episode of depression is at least three outpatient visits during the 12-week acute phase of treatment. One of the visits should be with the prescribing practitioner. ▪ Make certain the dose of medication is adequate. ▪ Titrate the dose upward, according to manufacturer and FDA recommendations and patient tolerance, when response is ineffective. ▪ If there is no improvement within 4-6 weeks non-behavioral health practitioners should consider consultation with a psychiatrist to verify the diagnosis and consider a substitute or augmentation strategy. ▪ Psychiatrists should consider verifying the diagnosis and substitution or augmentation strategies if there is no improvement in 4-6 weeks. <p><u>Continuation Phase of Treatment (6 months)</u></p> <ul style="list-style-type: none"> ▪ Review the need to continue treatment with the patient. ▪ Continue medication at the full therapeutic dose for 16-20 weeks after full remission of symptoms. Appropriate dosing and continuation of antidepressant therapy through the acute and continuation phases of treatment decreases recurrence of depression. ▪ Carefully monitor for signs of relapse, especially during the first 8 weeks of remission. <p><u>Maintenance Phase of Treatment</u></p> <ul style="list-style-type: none"> ▪ Consider the need for maintenance treatment when: <ul style="list-style-type: none"> • There is a co-morbid medical condition that is likely to complicate recovery • There is a history of multiple depressive disorders and poor inter-episode recovery • The current episode has lasted for 2 years or more • The current episode is a severe type ▪ Discuss treatment options with the patient, including benefits and risks.

Topic	Recommendations
Psychotherapy	Psychotherapy suggested therapy schedule would be: <ul style="list-style-type: none"> ▪ Initial two visits for assessment and formulation of a treatment plan. ▪ Up to eight, additional visits over the next 6 months ▪ Additional visits may be necessary based on specified treatment goals and progress toward those goals ▪ Referral to community services, such as Al Anon, Consumer Credit Counseling, or Victim Assistance as warranted ▪ Referral for Case Management services as warranted

Sources:

American Psychiatric Association. (1994) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, DC, American Psychiatric Association, 1994.

American Psychiatric Association. (1996). Major Depressive Disorder in Adults. In American Psychiatric Association (Eds.), Practice Guidelines (pp. 79-134). Washington, DC.

Friedman, E. (1997). Combined Therapy for Depression. Journal of Practical Psychiatry and Behavioral Health, 3: 211-222.

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Schatzberg, A. (1996). Course of Depression in Adults: Treatment Options. Psychiatric Annals, 26:336-341.

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Guidelines reviewed/updated:

11/25/98 - Approved by the SummaCare Behavioral Health Committee

9/27/00 - Reviewed/Updated by the SummaCare Behavioral Health Committee

8/28/02 - Reviewed/Updated by the SummaCare Behavioral Health Committee

3/25/04 – Reviewed/Approved by the SummaCare Behavioral Health Committee

7/22/04 – Reviewed/Updated by the SummaCare Behavioral Health Committee

12/13/07 – Reviewed/Updated by the SummaCare Behavioral Health Committee

7/23/09 – Reviewed/Updated by the SummaCare Behavioral Health Committee

PRESCRIBING GUIDELINES FOR ANTIDEPRESSANTS FOR PRIMARY CARE PHYSICIANS

This information is to be considered as a source of information for primary care physicians in their treatment of a major depressive disorder and is to be used in conjunction with the Treatment Guidelines for Major Depressive Disorder.

There are many classes of antidepressants to consider. Each of the antidepressants has individual benefits and is indicated for different types of depression. Along with the benefits, however, each medication class also has side effects to consider. Remember, not every patient responds to antidepressants in the same way. It may take a trial of a few different medications to find the most effective treatment.

Below are listed classes of antidepressants, the average starting dose, the recommended daily range and the major possible side effects of the medications as listed by the American Psychiatric Association. The provided information is only to be used as a quick reference. The information does not include all the clinical information relevant to the medication or all the side effects and safety information.

Selective serotonin reuptake inhibitors or SSRIs and newer antidepressant agents, should be the initial drugs of choice for depression. They are the “first line antidepressant agents. SSRI’s and the newer agents are found to have less serious side effects than other anti-depressants. They also are safer if the patient overdoses. The SSRI’s and newer agents are more expensive than older antidepressants such as the tricyclic medications. The SSRI’s and newer agents have been found effective for treatment of depression, anxiety and obsessive compulsive disorders.

The SSRI’s and newer antidepressant agents require minimal titration of dosages and may be effective at the starting dose. The medications do take 4-6 weeks to gain efficacy in treatment of the depressive symptoms. If one particular medication does not work to alleviate depressive symptoms after an appropriate treatment time, the physician may consider changing the prescription to a different medication.

Many of the SSRI’s are available in generic form including: Fluoxetine HCl, Fluvoxamine maleate, Mirtazapine, Paroxetine, Citalopram and Sertraline

Tricyclic medications or TCA’s, are considered the “older antidepressants” and may be prescribed for depressive symptoms that do not respond to other antidepressants. The TCA’s have more complicated side effects, have a higher lethality in the event of an overdose and may require specific expertise in dosing. Postural hypotension is the most dangerous side effect of the TCA’s. Consultation with a psychiatrist is recommended with their usage.

Monoamine oxidase inhibitors or MAO’s are also considered to be “older antidepressants”. Special considerations must be given to a patient’s diet when MAO’s are prescribed. Their side effects are more extensive and the MAO’s also have a high lethality in the event of an overdose. Again, consultation with a psychiatrist is recommended for their use.

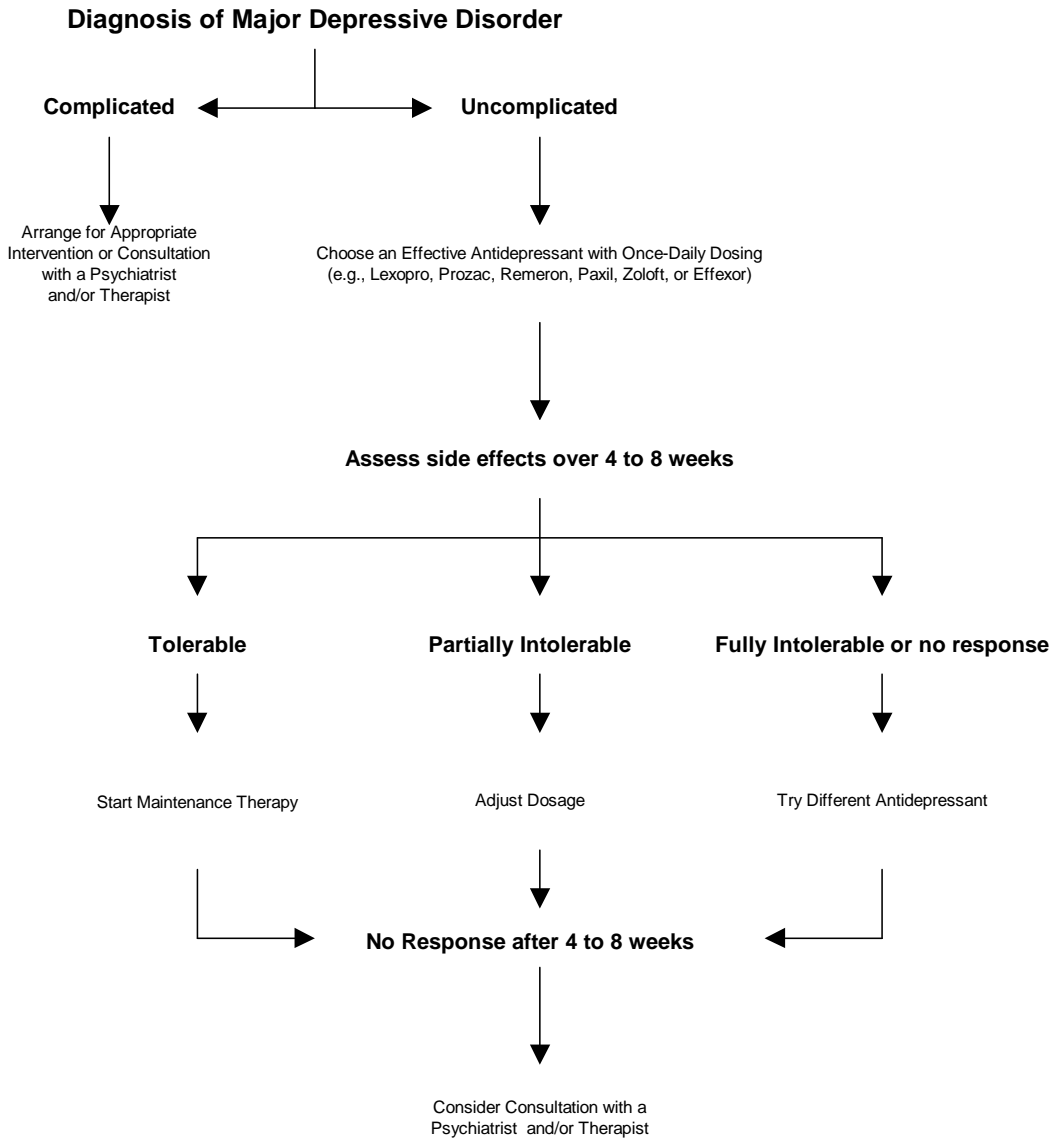
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U.S. Preventive Services Task Force. Screening for Depression: Recommendations and Rationale. Annuals of Internal Medicine 2002; 136: 760-764.

SummaCare Health Plan, Inc.
Decision Tree for Management of Depression



SummaCare Health Plan, Inc.
Profiles of Starting Dose, Effective Range and Side Effects of Common Antidepressant Medications

Selective Serotonin Re-Uptake Inhibitors

Tiers	Antidepressant Drug	Starting Dose	Effective Range	GI Disturbance	Sedation	Agitation	Weight Gain	Sexual Dysfunction	Drug Interactions
T1	Fluoxetine HCl (Prozac)	10-20 mg qd	20-60 mg/day	++	-	+	-	++	++
T1	Fluvoxamine maleate (Luvox)	25 mg bid	100-300 mg/day	++	+	-	-	+	++
T1 T3	Paroxetine HCl (Paxil) Paroxetine (Paxil CR)	10-20 mg qd	20-60 mg/day	++	++	-	+	+	+
T1	Sertraline HCl (Zoloft)	25-50 mg qd	50-200 mg/day	++	-	-	-	+	+
T3	Escitalopram (Lexapro)	10 mg qd	10-20 mg/day	+	0/+	-	-	+	-
T1	Citalopram (Celexa)	20 mg qd	20-60 mg/day	+	+	-	-	+	-

Other Antidepressant Agents

Tiers	Antidepressant Drug	Starting Dose	Effective Range	GI Disturbance	Sedation	Agitation	Weight Gain	Sexual Dysfunction	Drug Interactions
T1 T3 T3	Bupropion (Wellbutrin) Bupropion SR (Wellbutrin SR) Bupropion XL (Wellbutrin XL)	150 mg qd	300-450 mg/day	-	-	+	-	-	+
T1	Mirtazapine (Remeron)	7.5 –15 mg qd	15-45 mg/day	+	++	-	++	-	+
T2	Venlafaxine ER (Effexor XR)	37.5 mg qd	75-225 mg/day	++	-	+	-	+	+
T3	Duloxetine (Cymbalta)	40 mg qd	40-60 mg/day	+	+	-	-	-	+
T1	Trazedone (Desyrel)	50 mg qd	75-400 mg/day	++	+++	-	-	+	+

Tricyclic Agents

Tiers	Antidepressant Drug	Starting Dose	Effective Range	GI Disturbance	Sedation	Agitation	Weight Gain	Sexual Dysfunction	Drug Interactions
T1	Amitriptyline (Elavil)	25-50 mg qd	100-300 mg/day	+++	+++	++	+++	+	++
T1	Clomipramine (Anafranil)	25 mg qd	100-250mg/day	++	++	++	++	+	++
T1	Desipramine (Norpramin)	25-50 mg qd	100-300 mg/day	+	+	+	++	+	++
T1	Imipramine (Tofranil)	25-50 mg qd	100-300 mg/day	++	+	++	++	+	++

SIDE EFFECTS:

- + occasional problems**
- ++ some problems**
- +++frequent problems**
- no problems

PHARMACY BENEFIT GUIDELINES:

Members pay a **Tier 1** copay for most generic drugs and selected low cost brand name drugs.
 Members pay a **Tier 2** copay for higher cost generic drugs and formulary (“preferred”) brand name drugs.
 Members pay a **Tier 3** copay for non-formulary and highest cost brand name drugs.
Copay amounts may vary depending upon individual plans.