

ANTIDEPRESSANTS

NATIONAL AND STATE STANDARDS FOR ANTIDEPRESSANT PRESCRIBING REQUIRE:

- **Optimal Practitioner Contacts for Medication Management**—Members diagnosed with a new episode of depression and treated with antidepressants and had at least 3 follow-up contacts with a PCP or mental health practitioner coded with a mental health diagnosis within the first 84 days (12 weeks). At least one of the contacts must be with the prescribing practitioner.
- **Acute Phase**—Members with a new diagnosis of depression and treated with antidepressant medication and remained on an antidepressant drug during the entire 84 days.
- **Effective Continuation Phase**—Members with a new diagnosis of depression and treated with antidepressant medication and remained on an antidepressant drug for at least 6 months.

Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with MDD and other psychiatric disorders.

The symptoms of the serotonin syndrome are rigidity, fever, mental status changes (including confusion), a “happy drunk” state, loss of consciousness, and death.

The FDA recommends that patients treated concomitantly with a triptan and an SSRI/SNRI be informed of the possibility of serotonin syndrome (which may be more likely to occur when starting or increasing the dose of an SSRI, SNRI, or triptan) and should be carefully followed.



HOW TO CODE DEPRESSION

Use one of these codes:

- 296.2X (first episode of depression)
- 296.3X (recurring depression)
- 298.0X, 300.4 (chronic mild depression)
- 311 (depression not otherwise specified)

CODE THE FIFTH DIGIT FOR CLAIMS PURPOSES:

- .x1—mild
- .x2—moderate
- .x3—severe without psychotic features
- .x4—severe with psychotic features
- .x5—partial remission
- .x6—in full remission
- .x0—unspecified

WHO TO CALL

- If imminent risk of harm: **911**
- For referral for inpatient assessment: **1-877-712-5340**, 24 hours a day, 7 days a week
- For referrals for psychotherapy or psychiatric evaluation: **1-877-712-5340 ext. 4012**; www.harmonybehavioralhealth.com
- Pharmacy: **1-877-647-7473**; www.wellcare.com



Our mission includes partnering with clinicians to assure quality, cost-effective health care for your patients. In keeping with this mission, we seek your support of our evidence-based formulary, which includes many highly therapeutic generic medications. If you believe these choices are not clinically effective for any particular patient, we would encourage you to discuss your clinical plan and rationale with one of our clinical pharmacists.



BEHAVIORAL HEALTH MEDICATION QUICK REFERENCE GUIDE FOR PCPs





COMMON PREFERRED MEDICATIONS

ATYPICAL ANTIPSYCHOTICS

- Risperdal
- Seroquel

FIRST GENERATION ANTIPSYCHOTICS

- Haldol (haloperidol)
- Trilafon (perphenazine)

SSRI ANTIDEPRESSANTS

- Fluoxetine
- Paroxetine
- Citalopram
- Sertraline

NOVEL ANTIDEPRESSANTS

- Bupropion
- Mirtazapine

STIMULANTS

- Methylphenidate
- Amphetamine salts

MOOD STABILIZERS

- Lithium
- Valproic acid
- Carbamazepine

ANTIPSYCHOTICS

- Recognized indications—treatment of psychosis (hallucinations, delusions, and bizarre behavior).
- Atypicals may increase blood sugar so blood sugars should be monitored.
- Active psychosis should be treated by a psychiatrist.
- Medical specialty societies and other national medical consensus bodies discourage the use of antipsychotics for the treatment of attention deficit disorder, sleep disorders, or anxiety disorders.
- The American Academy of Child and Adolescent Psychiatry ADD/ADHD 2004 Guidelines do not recommend atypical antipsychotics for the treatment of ADD/ADHD.
- May cause tardive dyskinesia, an irreversible movement disorder.
- May cause neuroleptic malignant syndrome.

“BLACK BOX WARNING”

The FDA has linked off-label prescribing of atypical antipsychotic drugs to an increased risk of death in the elderly.

Risperidone, olanzapine, and aripiprazole increase the risk of cerebrovascular events, including stroke and an increased risk of death from stroke.

Risperidone and olanzapine may cause elevated blood sugar and diabetes.



ATTENTION DEFICIT DISORDER—ADD/ADHD

The American Academy of Child and Adolescent Psychiatry ADD/ADHD 2004 Guidelines:

- Do not recommend atypical antipsychotics for the treatment of ADD/ADHD.
- “Decision to treat with medications should be based on persistent target symptoms across at least 2 settings sufficiently severe to cause functional impairment and continuing efficacy of medication.”
- ADD/ADHD should not be diagnosed without report from teachers and the primary caregivers, ideally using standard measures (e.g., Conners’ rating scale).
- Stimulants are the first line treatment and FDA approved.
- Alpha-2 adrenergic agonists such as Catapres or Tenex are alternatives that are not FDA approved.
- There is a risk of abuse and cardiovascular complications with stimulants.



ADD/ADHD TREATMENT STRATEGIES

PLAN A:

- 1) Psycho-stimulant medication—begin with low doses; prescribe 2–3 daily divided doses; methylphenidate—maximum 2 mg/kg/d (60 mg/d).
- 2) Rapid adjustment (weekly) to optimal dose.
- 3) Periodic phone contacts and office visits.
- 4) When good response achieved, may consider long-acting preparation of some stimulant.
- 5) If poor response, go to Plan B.

PLAN B:

If response to one stimulant is ineffective (e.g., methylphenidate), then follow similar protocol for other category (i.e., amphetamine).

PLAN C:

Consider treatment with tricyclic antidepressants (Imipramine 25 mg daily).

- 1–2 week induction for therapeutic effects.
- Increased adverse events with doses >2 mg/kg/d.
- Always check FH of cardiac events, conduct PE, EKG, lab testing.