UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2017 P 4006-1
Program	Prior Authorization/Non-Formulary
Medication	Trintellix (vortioxetine)
P&T Approval Date	9/2017
Effective Date	1/1/2018; Oxford only: 1/1/2018

1. Background:

Trintellix* is a serotonergic antidepressant that is indicated for the treatment of major depressive disorder. American Psychiatric Association treatment guidelines for major depressive disorder state that the effectiveness of antidepressant medications is generally comparable between classes and within classes of medications.

2. Coverage Criteria[a]:

Initial Authorization

A. **Trintellix*** will be approved based on **one** of the following:

1. **Both** of the following:

   a. The member is new to the plan (as evidenced by coverage effective date of less than or equal to 120 days).

   -AND-

   b. The member is currently stabilized on Trintellix.

   Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

* Trintellix is typically excluded from coverage.

3. Additional Clinical Rules:

- Supply limits and/or Step Therapy may also be in place.

4. References:

1. Trintellix prescribing information. Takeda Pharmaceuticals, America. Deerfield, IL. April 2017.
2. American Psychiatric Association. Practice guideline for the treatment of patients with major depressive disorder, third edition. Oct. 2010. Available at: http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf

Program	Prior Authorization/Non-Formulary - Trintellix
Change Control	
9/2017	New program.