Program Number | 2018 P 2049-7
Program | Prior Authorization/Medical Necessity Oxford - Select Brand Medications
Medication/Therapeutic Class | Select Brand Medications – Aplenzin (bupropion extended-release), Celexa (citalopram), Effexor XR (venlafaxine extended-release), Forfivo XL (bupropion extended-release) and Pexeva (paroxetine)
P&T Approval Date | 4/2015, 5/2015, 11/2015, 2/2016, 10/2016, 10/2017, 10/2018
Effective Date | Oxford: 2/1/2019

1. **Background:**
FDA approved generic drug products are required to meet the same rigid standards as the brand innovator drug. All FDA approved generics have the same high quality, strength, purity and stability as brand drug, and generics must meet the same manufacturing quality standards.¹

This program requires a member to try a generic product(s) with the same active ingredient(s) prior to receiving coverage for Aplenzin, Celexa, Effexor XR, Forfivo XL, and Pexeva.

2. **Coverage Criteria**:  

A. The brand medications **Aplenzin, Celexa, Effexor XR, Forfivo XL and Pexeva** will be approved based on **one** of the following criteria:

1. **Both** of the following:
   
a. History of greater than or equal to 4 week trial of the therapeutically equivalent generic (Document date and duration of trial. For Aplenzin a trial of bupropion extended-release (generic Wellbutrin XL) is required. For Pexeva a trial of paroxetine (generic Paxil) is required)

   -AND-

   b. Submission of medical records documenting the inadequate response to the therapeutically equivalent generic

   -OR-

2. **Both** of the following:

   a. Documented history of intolerance to the therapeutically equivalent
generic which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. take with food to minimize nausea, take prior to bedtime to manage fatigue, take in the morning to manage insomnia, eat high-fiber diet with plenty of water to minimize constipation, etc.)

-AND-

b. Submission of medical records documenting the adverse effect of the therapeutically equivalent generic

**Authorization will be issued for 12 months**

* 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.

3. **Additional Clinical Programs:**
   - Supply limits may also apply.

4. **References:**
<table>
<thead>
<tr>
<th>Date</th>
<th>Change</th>
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<tbody>
<tr>
<td>4/2015</td>
<td>New program</td>
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<tr>
<td>5/2015</td>
<td>Added Abilify to program and changed program name from Brand Antidepressants to Select Brand Medications.</td>
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<tr>
<td>11/2015</td>
<td>Changed authorization period. Added clarification to therapeutic equivalent language.</td>
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<tr>
<td>2/2016</td>
<td>Added Treximet to program.</td>
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<tr>
<td>10/2016</td>
<td>Removed Abilify, Cymbalta, Lexapro, Prozac, Treximet, Wellbutrin SR, Wellbutrin XL and Zoloft from Oxford only criteria.</td>
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<tr>
<td>10/2018</td>
<td>Annual review. Updated references.</td>
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