1. **Background:**

Step Therapy programs are utilized to encourage the use of lower cost alternatives for certain therapeutic classes. This program requires a member to try the lower cost alternatives before coverage will be provided for Seroquel XR.

2. **Coverage Criteria**:

A. **Initial Authorization**

1. **Seroquel XR** will be approved based on the following criteria:

   a. **ONE** of the following:

   (1) Diagnosis of major depressive disorder, and used in combination with an antidepressant, and history of failure, contraindication, or intolerance to all of the following:

   (a) At least one selective serotonin reuptake inhibitor (SSRI) (document duration and drug tried)

   -AND-

   (b) At least one of the following: serotonin norepinephrine reuptake inhibitor (SNRI), mirtazapine, or bupropion (document duration tried).

   -AND-

   (c) At least one of the following atypical antipsychotics approved by the FDA for the adjunctive treatment of major depressive disorder with an antidepressant (document duration tried):

      i. olanzapine (generic Zyprexa)

      ii. quetiapine (generic Seroquel)
(2) Any other diagnosis and history of failure, contraindication, or intolerance to BOTH of the following (list reason for therapeutic failure, contraindication, or intolerance):

(a) quetiapine (generic Seroquel)
(b) TWO of the following:
   i. olanzapine (generic Zyprexa)
   ii. risperidone (generic Risperdal)
   iii. ziprasidone (generic Geodon)

(3) Treatment was initiated at a recent behavioral inpatient admission (discharge within the past 3 months) and the member is currently stable on therapy. (document date of discharge from inpatient admission).

(4) The member is new to the plan (as evidenced by coverage effective date of less than or equal to 120 days) and currently stabilized on therapy.

Authorization will be issued for 12 months

B. Reauthorization

1. Documentation of positive clinical response

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

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.
4. **References:**


<table>
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<tr>
<th>Program</th>
<th>Step Therapy – Seroquel XR</th>
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<tbody>
<tr>
<td><strong>Change Control</strong></td>
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<tr>
<td>Date</td>
<td>Change</td>
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<tr>
<td>10/2016</td>
<td>New program.</td>
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<tr>
<td>1/2017</td>
<td>Administrative change. Clarified applies to Essential PDL only.</td>
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<tr>
<td>10/2017</td>
<td>Annual review. Added reauthorization criteria.</td>
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<tr>
<td>10/2018</td>
<td>Annual review. Removed drug and date documentation requirement.</td>
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<td>10/2019</td>
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