TUFTS Health Plan

# Pharmacy Medical Necessity Guidelines: Anti-anxiety Medications

*Effective: July 20, 2020*

| Prior Authorization Required | √ | Type of Review – Care Management | |
|---|---|---|---|
| Not Covered | | Type of Review – Clinical Review | √ |
| Pharmacy (RX) or Medical (MED) Benefit | RX | Department to Review | RXUM |

These pharmacy medical necessity guidelines apply to the following:

**Commercial Products**

☐ Tufts Health Plan Commercial products – large group plans
☐ Tufts Health Plan Commercial products – small group and individual plans
☐ Tufts Health Freedom Plan products – large group plans
☐ Tufts Health Freedom Plan products – small group plans
- CareLink℠ – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

**Tufts Health Public Plans Products**

☐ Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product)
☒ Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans
☐ Tufts Health RITogether – A Rhode Island Medicaid Plan

**Fax Numbers:**
RXUM: 617.673.0988

**Note:** This guideline does not apply to Medicare Members (includes dual eligible Members).

## OVERVIEW

**FDA-APPROVED INDICATIONS**

Buspirone is indicated for the management of anxiety disorders or the short-term relief of the symptoms of anxiety.

The MassHealth Pediatric Behavioral Health Medication Initiative (PBHMI) has been implemented to encourage safe prescribing of behavioral health medication regimens in members less than 18 years of age. As part of the PBHMI, a prior authorization is required for pediatric members less than 6 years of age who are being prescribed a benzodiazepine or buspirone, regardless as to whether the medication is preferred on the Plan's formulary. Table 1 lists the anti-anxiety medications that are included in the PBHMI. Of note, **short-acting intramuscular injectable and intravenous formulations are excluded from the Pediatric Behavioral Health Medication initiative requirements.**

**Table 1. Medications in the PBHMI**

| Drug Name | Generic Name | For members < 6 years of age | For members ≥ 6 years of age |
|---|---|---|---|
| Alprazolam tablet | Alprazolam | PA | Covered |
| Alprazolam ER | Alprazolam extended-release | PA | Covered |
| Alprazolam Intensol | Alprazolam oral concentrate | PA | Covered |
| Alprazolam ODT | Alprazolam orally disintegrating tablet | PA | Covered |
| Buspirone | Buspirone | PA | 5 mg, 7.5 mg, 10 mg, 15 mg: covered<br>30 mg: PA |
| Chlordiazepoxide | Chlordiazepoxide | PA | Covered |
| Chlordiazepoxide/amitriptyline | Chlordiazepoxide/amitriptyline | Not Covered | Not Covered |
| Clonazepam | Clonazepam | PA | Covered |
| Clorazepate | Clorazepate | PA | Covered |

| Drug Name | Generic Name | For members < 6 years of age | For members ≥ 6 years of age |
|---|---|---|---|
| Diazepam | Diazepam | PA | Covered |
| Diazepam Intensol | Diazepam oral concentrate | PA | Covered |
| Lorazepam | Lorazepam | PA | Covered |
| Lorazepam Intensol | Lorazepam oral concentrate | PA | Covered |
| Meprobamate | Meprobamate | Not Covered | Not Covered |
| Midazolam | Midazolam | Not Covered | Not Covered |
| Oxazepam | Oxazepam | PA | Covered |

## COVERAGE GUIDELINES

In addition to medication-specific prior authorization criteria, the Plan may authorize coverage of a preferred or non-preferred anti-anxiety medication for Members less than 6 years of age when **all** the following criteria are met:

***Age-Specific Criteria***

**Benzodiazepine for Members less than 6 years of age**:

1. Member has one of the following:
   a) Recent psychiatric hospitalization (within the last three months)
   **OR**
   b) History of severe risk of harm to self or others
   **OR**
   c) A seizure diagnosis only

**OR**

Member has all of the following:
   a) An appropriate diagnosis
   **AND**
   b) Treatment plan, including the names of current behavioral health medications and corresponding indications
   **AND**
   c) Prescriber is a specialist (e.g., neurologist, psychiatrist) or a consult is provided

**Buspirone or Meprobamate for Members less than 6 years of age:**

1. Member has one of the following:
   a) Recent psychiatric hospitalization (within the last three months)
   **OR**
   b) History of severe risk of harm to self or others

**OR**

Member has all of the following:
   a) An appropriate diagnosis
   **AND**
   b) Treatment plan, including the names of current behavioral health medications and corresponding diagnoses
   **AND**
   c) Prescriber is a specialist (e.g., neurologist, psychiatrist) or a consult is provided

***Medication-Specific Criteria***

The plan may authorize coverage of a non-preferred anti-anxiety medication for Members 6 years of age or older when all of the following criteria are met. If the Member is less than 6 years of age, the age-specific criteria listed above must be met first in addition to the medication-specific criteria listed below:

***Buspirone 30 mg tablets:***

1. The Member had an inadequate response to or the provider indicates clinical inappropriateness of therapy with two 15 mg buspirone tablets

**Upon Renewal**

1. The Member had an office visit in the past year, was reassessed for the condition, and continued therapy with the medication is considered medically necessary.

## LIMITATIONS

1. The length of approval for anti-anxiety medications will be for 2 years.
2. Non-covered antianxiety medications reviewed under the PBHMI criteria for members less than 6 years age will also be reviewed according to the Noncovered Medications criteria.
3. Requests for members exceeding the PBHMI polypharmacy limits will also be reviewed against the PBHMI polypharmacy criteria.
4. Samples, free goods, or similar offerings of the requested medication do not qualify for an established clinical response or exception, but will be considered on an individual basis for prior authorization.

## CODES

None

## REFERENCES


1. Buspar (buspirone) [prescribing Information] Princeton, NJ; Bristol-Myers Squibb; November 2010.
2. Lexi-Drugs Online: Buspirone [cited May 26, 2015]. Available from: http://online.lexi.com/crlsql/servlet/crlonline
3. Lexi-Drugs Online: Meprobamate [cited May 26, 2015]. Available from: http://online.lexi.com/crlsql/servlet/crlonline
4. National Collaborating Centre for Mental Health, National Collaborating Centre for Primary Care. Generalised anxiety disorder and panic disorder (with or without agoraphobia) in adults. Management in primary, secondary and community care. London, UK: National Institute for Health and Clinical Excellence (NICE); 2011.
5. Bandelow B, Sher L, Bunevicius R, Hollander E., Siegfried K. Guidelines for the pharmacological treatment of anxiety disorders, obsessive – compulsive disorder and posttraumatic stress disorder in primary care. International Journal of Psychiatry in Clinical Practice 2013: 16: 77-84.
6. Meprobamate [prescribing information]. Bridgewater, NJ: Alembic Pharmaceuticals; March 2019.


## APPROVAL HISTORY

June 9, 2015: Reviewed by Pharmacy & Therapeutics Committee; incorporated criteria for buspirone and established drug-specific criteria for meprobamate; added criteria for Members less than 6 years of age.

Subsequent endorsement date(s) and changes made:

1. September 15, 2015: Approval duration modified to life of plan for Members less than 6 years of age and for buspirone. Approval duration modified to 2 years for meprobamate.
2. January 1, 2016: Administrative change to rebranded template.
3. September 13, 2016: Modified approval criteria for members less than 6 years of age. Added benzodiazepines falling under the PBHMI to the policy.
4. May 9, 2017: Administrative update, Adding Tufts Health RITogether to the template.
5. December 12, 2017: No changes.
6. December 11, 2018: Administrative updates made to template.
7. October 15, 2019: Administrative update, added to limitations section of the MNG that requests for members exceeding the PBHMI polypharmacy limits will also be reviewed against the PBHMI polypharmacy criteria.
8. April 14, 2020: Effective July 1, 2020, removed medication-specific criteria for meprobamate from the MNG, as it is Not Covered. Clarified renewal criteria so that it applies to all agents in the MNG.
9. July 14, 2020: Administrative update, added language concerning samples to the limitations section of the MNG.

## BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined

population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.