

## **Clinical Policy: Vilazodone (Viibryd)**

Reference Number: CP.PMN.145

Effective Date: 08.01.12

Last Review Date: 08.24

Line of Business: Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Vilazodone (Viibryd<sup>®</sup>) is an antidepressant.

### **FDA Approved Indication(s)**

Viibryd is indicated for the treatment of major depressive disorder.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Viibryd is **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Major Depressive Disorder (must meet all):**

1. Diagnosis of major depressive disorder;
2. Age  $\geq$  18 years;
3. Failure of TWO of the following, each tried for  $\geq$  4 weeks at up to maximally indicated doses, unless clinically significant adverse effects are experienced or all are contraindicated: selective serotonin reuptake inhibitor (SSRI), serotonin norepinephrine reuptake inhibitor (SNRI), bupropion, mirtazapine;
4. If request is for Viibryd, member must use generic vilazodone, unless contraindicated or clinically significant adverse effects are experienced;
5. Dose does not exceed both of the following (a and b):
  - a. 40 mg per day;
  - b. 1 tablet per day.

**Approval duration: 12 months**

##### **B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or

- b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

## **II. Continued Therapy**

### **A. Major Depressive Disorder (must meet all):**

1. Currently receiving medication via Centene benefit or documentation supports that member is currently receiving Viibryd for a covered indication and has received the medication for at least 30 days;
2. Member is responding positively to therapy;
3. If request is for Viibryd, member must use generic vilazodone, unless contraindicated or clinically significant adverse effects are experienced;
4. If request is for a dose increase, new dose does not exceed both of the following (a and b):
  - a. 40 mg per day;
  - b. 1 tablet per day.

**Approval duration: 12 months**

### **B. Other diagnoses/indications (must meet 1 or 2):**

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
  - a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.PMN.255 for Medicaid; or
  - b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.PMN.53 for Medicaid.

## **III. Diagnoses/Indications for which coverage is NOT authorized:**

- A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.PMN.53 for Medicaid or evidence of coverage documents.

#### IV. Appendices/General Information

##### *Appendix A: Abbreviation/Acronym Key*

FDA: Food and Drug Administration

MAOI: monoamine oxidase inhibitor

SNRI: serotonin norepinephrine reuptake inhibitor

SSRI: selective serotonin reuptake inhibitor

##### *Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
bupropion (Wellbutrin <sup>®</sup> XL)	150-450 mg PO QAM	450 mg/day
bupropion (Wellbutrin SR)	150 mg PO QAM or 150-200 mg PO BID	400 mg/day
mirtazapine (Remeron <sup>®</sup> )	15-45 mg PO QHS	45 mg/day
<b>SSRIs</b>		
citalopram (Celexa <sup>®</sup> )	20 mg PO QD	40 mg/day ( $\leq$ 60 years) 20 mg/day ( $>$ 60 years)
escitalopram (Lexapro <sup>®</sup> )	10-20 mg PO QD	20 mg/day
fluvoxamine*	50-300 mg PO QD	300 mg/day
fluoxetine (Prozac <sup>®</sup> )	20 mg PO QD	80 mg/day
paroxetine (Paxil <sup>®</sup> )	20 mg PO QD	50 mg/day
paroxetine controlled release (Paxil CR <sup>®</sup> )	25 mg PO QD	62.5 mg/day
sertraline (Zoloft <sup>®</sup> )	50 mg PO QD	200 mg/day
<b>SNRIs</b>		
desvenlafaxine (Pristiq <sup>®</sup> )	50 mg PO QD	400 mg/day
duloxetine (Cymbalta <sup>®</sup> )	20 mg PO BID, 30 mg BID, or 60 mg PO QD	120 mg/day
Venlafaxine (Effexor <sup>®</sup> XR)	75 mg PO BID to TID	225 mg/day
Fetzima <sup>®</sup> (levomilnacipran)	40-120 mg PO QD	120 mg/day

\*Off-label

*Therapeutic alternatives are listed as Brand name<sup>®</sup> (generic) when the drug is available by brand name only and generic (Brand name<sup>®</sup>) when the drug is available by both brand and generic.*

##### *Appendix C: Contraindications / Boxed Warnings*

- Contraindication(s): Concomitant use of monoamine oxidase inhibitors (MAOIs) or use within 14 days of stopping MAOIs because of an increased risk of serotonin syndrome.
- Boxed warning(s): suicidal thoughts and behaviors in pediatric and young adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening and for emergence of suicidal thoughts and behaviors. Viibryd is not approved for use in pediatric patients.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Major depressive disorder	10 mg orally daily for 7 days, followed by 20 mg once daily	40 mg/day

**VI. Product Availability**

Tablet: 10 mg, 20 mg, 40 mg

**VII. References**

1. Viibryd Prescribing Information. North Chicago, IL. AbbVie, Inc.; October 2023. Available at: <https://www.viibryd.com/>. Accessed May 9, 2024.
2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2024. Updated periodically. Accessed May 9, 2024.
3. Gelenberg AJ, Freeman MP, Markowitz JC, et al. Practice guideline for the treatment of patients with major depressive disorder, third edition. Arlington, VA: American Psychiatric Association; May 2010. Available online at: [https://psychiatryonline.org/pb/assets/raw/sitewide/practice\\_guidelines/guidelines/mdd.pdf](https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf) Accessed May 9, 2024.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
3Q 2020 annual review: no significant changes; references reviewed and updated.	05.06.20	08.20
3Q 2021 annual review: shortened the trial durations of alternative agents from 8 weeks to 4 weeks; added bupropion and mirtazapine as additional options for trial; combined trial requirements by providing an option to try any two among SSRI, SNRI, bupropion, and mirtazapine; updated reference for HIM off-label use to HIM.PA.154 (replaces HIM.PHAR.21); references reviewed and updated.	07.20.21	08.21
3Q 2022 annual review: no significant changes; updated black box warning verbiage per PI; references reviewed and updated.	03.22.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.04.22	
3Q 2023 annual review: HIM line of business removed as PA is no longer required; added requirement if request is for Viibryd, member must use generic vilazodone; references reviewed and updated.	04.18.23	08.23
3Q 2024 annual review: revised continued therapy to allow continuity of care for antidepressants; in Appendix B, added Wellbutrin SR to therapeutic alternatives and clarified that fluvoxamine used in depression is off-label; references reviewed and updated.	05.29.24	08.24

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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