PROVIDERS PLEASE NOTE: Adult Depression Treatment Flow Diagram As of January 1, 2022, the pharmacy benefit for all Medi-Cal enrollees (including Partnership members) is administered (MPXG5003 Policy Attachment A) through DHCS State Medi-Cal Fee-for-Service. Check the State Medi-Cal Provider Manuals for information on covered drugs and how to submit TARS on/after 1/1/2022. Web links are provided for your convenience (see references). By: Jeffrey DeVido, MD 10/09/2024 In addition to **PROVIDERS PLEASE NOTE:** pharmacotherapy, Medi-Cal mental health treatment services are divided between county Start consider also specialty mental health (SMH) and managed care plan non-specialty mental Full assessment including epression screening too referral for health (NSMH) programs. The differentiation is based on clinical severity, Diagnosis (DSM-5) of and/or depression medical work up for psychotherapy non-psychotic unipolar with higher severity patients being preferentially routed to SMH systems of assessment tool (i.e., medical causes of (or major depressive PHQ-9, HAM-D, BDI, care. [See: MCUP3028] contributors to) disorder MADRS) depressed mood High risk factors for **Factors to consider** Reasons for poor when selecting an response to recurrence: Has the patient had an adequate trial of an SSRI such as Medical conditions and Individuals who answer Also consider contextual antidepressant for antidepressant subthreshold sertraline, escitalopram, fluoxetine, or citalopram? "yes" to PHQ-9 question treatments often associated psychosocial factors that treatment of Major medications depressive "Adequate trial" typically is 4-6 weeks (consistent dosing) at pertaining to thoughts can contribute to with depressed mood: **Depressive Disorder** Adherence symptoms persist adequate dose depression (e.g., about self harm (or HIV/AIDS, Hepatitis. Inadequate dosing • Prior history of Per history and/or otherwise indicate Mononucleosis, UTI, TB, financial/food/housing records, has the Inadequate duration multiple depressive suicidal thinking during PNA, COVID-19 insecurity, recent patient had previous of treatment episodes interview) require further • Addison's and Cushing's significant losses) Inaccurate Severity of initial depression evaluation and suicide diseases, Thyroid disease, pharmacotherapy diagnosis episode risk stratification. Renal disease, Diabetes, Undiagnosed • Earlier age of onset trials that have been pharmacotherapy See VA/DoD Clinical Pituitary dysfunction Persistent sleep effective? psychiatric • Brain tumor, Dementia, decisions should Practice Guidelines (refer • Side effect profile comorbities (e.g. disturbance Consider trying to Partnership Policy MIgraine HA, Parkinson's, be made through Drug-drug personality Presence of a an SSRI, such MPXG5003 Reference MS, Seizure disorders, TBI shared decision interactions disorders, general medical as: sertraline. section or this · Cancer, Arthritis, CVA, MI, • Safety in overdose making model substance use disorder escitalopram, attachment's References Fibromyalgia, Liver failure, Family history of · Family history of disorders) or citalopram or, Premenstrual dysphoric treatment response to significant mood medical fluoxetine Resources page for the disorder, Sleep the medication cormorbidities disorder web address). disturbance, Menopause, • Patient Preference Drug-drug Consider one of the following • Optimize Dose IBS, Chronic pain, Anemia interactions (take into account patient • Consider switching agents or Concomitant medications Undiagnosed Always screen for the preference and side effect augmenting treatment as outlined that can cause depression sence of, or the history psychosocial factors profile) in "NO response" of, Bipolar Disorder, as (e.g., anticonvulsants, • Switching to a different agent from • Consider factors listed in "Reasons antidepressant benzodiazepines, the above node for poor response to antidepressant pharmacotherapy may Continue treatment for 4-9 months. barbiturates, beta increase the risk of **Switching** to a dual-acting agent medications" table. blockers, calcium channel then re-assess precipitating mania in (venlafaxine, duloxetine, • Consider psychiatry consultation Deprescribe as clinically appropriate, blockers, opioids, statins, those individuals mirtazapine, vilazodone, f patient is high risk of recurrence, then in shared-decision making framework antivirals) vortioxetine) consider ongoing maintenance with the patient Switching to or Augmenting with treattment (12-36 months) (seerisk Avoid abrupt discontinuations **Remission or** bupropion (especially if sexual side factor box) NOTE: This document is not intended to provide or infer ically meaningf effects) DHCS TAR requirements for a drug that is not on the response? Augmenting with quetiapine, State CDL. State TAR criteria are not available publically risperidone, or aripiprazole reatment resistant depression Note that the Note that STATE TAR may be **Augmenting** with bupropion or • Consider SMH referral and/or at this time. combination of required for mirtazapine psychiatry consultation medications • Augmenting with Lithium or T3 treatment of Treatment Resistant • Consider **switching** to third line increases the However, it is reasonable to consider that Augmenting with symptomagent (e.g., tricyclic antidepressan Depression, including use of likelihood of side targeted medications (e.g., MAOi) **consider side effect, drug documentation of adequate trials of State-covered adjunctive agents or progressing to trazodone if insomnia, buspirone or drug, and safety profile** effects antidepressants would be the MINIMUM that should be other 2nd/3rd/4th line hydroxyzine if anxious) • Consider trial of esketamine, or included on a TAR, together with any additional patientpharmacotherapies Consider psychiatry consultation TMS/ECT specific justification.

Depression pharmacotherapies are the responsibility of State Medi-Cal. If the pharmacotherapy is on the State Medi-Cal Covered Drug List (CDL), then no TAR is required. If the pharmacotherapy is not on the CDL then a TAR is required (submitted to Medi-Cal RX, not PHC).

This algorithm is drawn from several sources listed below. This algorithm is not intended to be comprehensive or definitive; rather, it aims to provide one possible approach to depression pharmacotherapy that could be considered in primary care practice settings.

- Osser, DN (ed). Psychopharmacology Algorithms: Clinical Guidance from the Psychopharmacology Algorithm Project at the Harvard South Shore Psychiatry Residency Program. Wolters Kluwer, New York, 2021.
- Schatzberg, AF and Nemeroff CB (eds). The American Psychiatric Association Publishing Textbook of Psychopharmacology, 5th Ed. APA Publishing, Arlington, VA, 2017.