Clinical Policy: Quetiapine ER (Seroquel XR)

Reference Number: CP.PMN.64
Effective Date: 12.01.14
Last Review Date: 02.18
Line of Business: Commercial, HIM, Medicaid Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Quetiapine ER (Seroquel XR®) is an atypical antipsychotic.

FDA Approved Indication(s)

Seroquel XR is indicated for the treatment of:

- Schizophrenia
- Bipolar I disorder, manic or mixed episodes
- Bipolar disorder, depressive episodes
- Major depressive disorder, adjunctive therapy with antidepressants.

Policy/Criteria

Provider must submit documentation (including 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® that Seroquel XR is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Schizophrenia (must meet all)**:**

1. Diagnosis of schizophrenia;
2. Age ≥ 13 years;
3. Failure of ≥ 4 week trial of quetiapine immediate-release (IR) at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
4. Does not exceed 800 mg per day (2 tablets/day).

Approval duration:
HIM - 12 months
Commercial/Medicaid - Length of Benefit

B. Bipolar Disorder (must meet all)**:**

1. Diagnosis of bipolar disorder;
2. Age ≥ 10 years;
3. Failure of ≥ 4 week trial of quetiapine IR at up to maximally indicated doses unless contraindicated or clinically significant adverse effects are experienced;
4. Dose does not exceed 800 mg per day (2 tablets/day).

Approval duration:
HIM - 12 months

Commercial/Medicaid - Length of bBenefit

C. Major Depressive Disorder (must meet all)**:**
1. Diagnosis of major depressive disorder;
2. Age ≥ 18 years;
3. Failure of **THREE antidepressants** (e.g., SSRI, SNRI, TCA, bupropion, mirtazapine, etc.) from at least **TWO different classes** at up to maximally indicated doses each trialed for ≥ 4 weeks, unless member is unable to satisfy this requirement due to clinically significant adverse effects or contraindication(s) to multiple antidepressants;
4. Failure of ≥ 4 week trial of aripiprazole used concurrently with an antidepressant at up to maximally indicated doses, unless contraindicated or clinically significant adverse effects are experienced;
5. Seroquel XR is prescribed concurrently with an antidepressant;
6. Dose does not exceed 300 mg per day (2 tablets/day).

Approval duration:
HIM - 12 months
Commercial/Medicaid - Length of Benefit

D. Other diagnoses/indications
1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. All Indications in Section I (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Documentation supports that member is currently receiving Seroquel XR for schizophrenia or bipolar disorder and has received this medication for at least 30 days;
2. If request is for a dose increase, new dose does not exceed:
   a. Schizophrenia, bipolar disorder: 800 mg/day (2 tablets/day);
   b. Major depressive disorder: 300 mg/day (2 tablets/day).

Approval duration:
HIM - 12 months
Commercial/Medicaid - Length of benefit

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.
   Approval duration: Duration of request or 6 months (whichever is less); or
2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is

NOT authorized): CP.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and 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.CPA.09 for commercial, HIM.PHAR.21 for health insurance marketplace, and CP.PMN.53 for Medicaid or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

FDA: Food and Drug Administration
IR: immediate-release
SNRI: serotonin/norepinephrine reuptake inhibitor
SSRI: selective serotonin reuptake inhibitor
TCA: tricyclic antidepressant

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
Quetiapine IR (Seroquel®)	Bipolar Mania or Maintenance: *Adults*: 50 mg PO BID, increased in increments of 100 mg/day as tolerated to 400 mg/day on Day 4; may further increase to 800 mg/day by Day 6 *Children*: 25 mg PO BID on Day 1, 50 mg BID on Day 2, 100 mg BID on Day 3, 150 mg BID on Day 4, and 200 mg BID beginning Day 5; may increase to 600 mg/day as needed Bipolar Depression: *Adults*: 50 mg QHS on Day 1, 100 mg on Day 2, 200 mg on Day 3, 300 mg on Day 4 and thereafter Schizophrenia: *Adults*: 25 mg PO BID on Day 1, increased by 25-50 mg on Day 2 and 3 to a target of 300-400 mg/day in divided doses 2-3 times per day by Day 4; may increase up to 800 mg/day *Adolescents*: 25 mg PO BID on Day 1, 50 mg BID on Day 2, 100 mg BID on Day 3,	Bipolar mania/ maintenance: *Adults*: 800 mg/day *Children*: 600 mg/day Bipolar depression: *Adults*: 300 mg/day Schizophrenia: *Adults, adolescents*: 800 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	150 mg BID on Day 4, and 200 mg BID beginning Day 5; may increase up to 800 mg/day	
aripiprazole (Abilify®)	10-30 mg by mouth daily	30 mg/day
citalopram (Celexa®)	20 mg by mouth daily	40 mg/day
escitalopram (Lexapro®)	10-20 mg by mouth daily	20 mg/day
fluvoxamine (Luvox CR®)	50-300 mg by mouth daily	300 mg/day
fluoxetine (Prozac®)	20 mg by mouth daily	80 mg/day
paroxetine (Paxil®)	20 mg by mouth daily	50 mg/day
sertraline (Zoloft®)	50 mg by mouth daily	200 mg/day
Duloxetine (Cymbalta)	20 mg twice daily	60 mg/day
venlafaxine (Effexor®)	75 mg/day by mouth twice to three times daily	375 mg/day
mirtazapine (Remeron® or Remeron® SolTab)	15 mg by mouth daily	45 mg/day
bupropion (Wellbutrin®)	100 mg by mouth three times daily	450 mg/day
Amitriptyline (Elavil)	75 mg per day	150 mg/day
nortriptyline (Pamelor)	25 to 50 mg per day	150 mg/day

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

Appendix C: General Information
Seroquel XR has a black box warning for increased mortality in elderly patients with dementia-related psychosis; and suicidal thoughts and behaviors.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
Schizophrenia in adults	Initial: 300 mg/day Target: 400-800 mg/day	800 mg/day
Schizophrenia in adolescents	Initial: 50 mg/day Target: 400-800 mg/day	

Indication	Dosing Regimen	Maximum Dose
Bipolar I disorder – manic or mixed episodes in adults	Initial: 300 mg/day Target: 400-800 mg/day	
Bipolar I disorder – manic episodes in children and adolescents	Initial: 50 mg/day Target: 400-600 mg/day	600 mg/day
Bipolar I disorder – depressive episodes in adults	Initial: 50 mg/day Target: 300 mg/day	300 mg/day
Major depressive disorder	Initial: 50 mg/day Target: 150-300 mg/day	

VI. Product Availability

Extended-release tablets: 50 mg, 150 mg, 200 mg, 300 mg, and 400 mg

VII. References

1. Seroquel XR Prescribing Information. Wilmington, DE: AstraZeneca Pharmaceuticals LP; February 2017. Available at: www.seroquelxr.com. Accessed November 2, 2017.
2. Lehman AF, Lieberman JA, Dixon LB, et al. Practice guideline for the treatment of patients with schizophrenia, second edition. Arlington, VA: American Psychiatric Association; February 2004. Available online at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. Accessed November 2, 2017.
3. Dixon L, Perkins D, Calmes C. Guideline watch: practice guideline for the treatment of patients with schizophrenia. Arlington, VA: American Psychiatric Association; September 2009. Available online at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. Accessed November 2, 2017.
4. Hirschfeld RMA, Bowden CL, Gitlin MJ, et al. Practice guideline for the treatment of patients with bipolar disorder, second edition. Arlington, VA: American Psychiatric Association; April 2002. Available online at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. Accessed November 2, 2017.
5. Hirschfeld RMA. Guideline watch: practice guideline for the treatment of patients with bipolar disorder. Arlington, VA: American Psychiatric Association; November 2005. Available online at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. Accessed November 2, 2017.
6. 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 http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm. Accessed November 2, 2017.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New guideline created – replaces CP.PMN.56	08.15	08.15
For bipolar disorder: removed the criterion requiring that member does not have contraindication to active quetiapine; For schizophrenia: modified criteria to require the use of quetiapine IR and one other generic PDL agent indicated for schizophrenia;	10.15	11.15

Reviews, Revisions, and Approvals	Date	P&T Approval Date
For depression: Added requirement for trial of 3 PDL antidepressants and added additional instruction on aripiprazole use and approval since aripiprazole requires a prior authorization.		
Converted to new integrated template. Updated references to include current practice guidelines rather than UpToDate. Removed age restrictions as they are not absolute contraindications per FDA labeling. Modified generalized FDA approved limit to specific dosing requirement; MDD: Added trial duration of 4 weeks. Modified requirement for trials to be of PDL antidepressants to include any antidepressants. Removed instruction on aripiprazole use and approval since member will qualify for aripiprazole so long as all other MDD criteria are met.	08.16	11.16
Converted to new template. All indications: Added age limits based on established safety and efficacy per PI. Schizophrenia and bipolar: Removed requirement that trialed antipsychotics must be generic to give credit to members who have tried branded products. Re-auth: Removed MDD from COC criteria as it is not a diagnosis eligible for COC. Removed the following from schizophrenia and bipolar disorder Per SDC guidance: Failure of a ≥ 4 week trial of one additional PDL atypical antipsychotic indicated for schizophrenia at up to maximally indicated doses, unless all are contraindicated or clinically significant adverse effects are experienced;	07.28.17	11.17
1Q18 annual review: - Policies combined for Centene Medicaid, Marketplace and Commercial lines of business - No significant changes - References reviewed and updated	12.01.14	02.18
Medicaid: changed approval duration from 12 months to length of benefit	03.04.18	05.18

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.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.

For Health Insurance Marketplace members, when applicable, this policy applies only when the prescribed agent is on your health plan approved formulary. Request for non-formulary drugs must be reviewed using the formulary exception policy.