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Dear Colleague,

The MassHealth Pharmacy Program and the Massachusetts Department of Mental Health would like to continue our ongoing dialogue with you regarding best practices for prescribing second generation antipsychotic medications. In doing so, our goal is to continue our efforts in advancing high quality, cost-effective care for MassHealth members. Because we have worked with you to successfully reduce the clinically inappropriate use of low dose Seroquel (quetiapine) to treat insomnia, we hope that focusing a new dialogue concerning best practices for the treatment of major depressive disorder (aka unipolar depression) will also be helpful.

According to the American Psychiatric Association (APA) 2010 Guidelines, the Canadian Network for Mood and Anxiety Treatments (CANMAT) Clinical Guidelines for the Management of Major Depressive Disorder in Adults (2009), and the Institute for Clinical Systems Improvement (ICSI) Healthcare Guidelines for Major Depression in Adults in Primary Care (2009), all antidepressants have the same probability of producing response and remission.[1-3] However, use of a selective serotonin reuptake inhibitor (SSRI) is commonly chosen first due to ease of use, good tolerability, and low cost.[1-3] Unfortunately, only 60% of patients will respond to SSRIs and 40% will remit with this initial option.[4] Therefore, if after a trial of an SSRI for 4 – 8 weeks at a therapeutic dose there is continued suboptimal outcome, the recommended next steps consist of three options as outlined below:[1-4]

Option 1- a trial of a different antidepressant: either within class or from another class. Option 2- addition of another antidepressant from a different class. Examples of effective combinations consist of an SSRI with bupropion or mirtazapine or an SNRI with mirtazapine. Option 3- addition of another medication not from the antidepressant class. This typically consists of an SSRI with lithium, triiodothyronine (T_3), buspirone, or a second generation antipsychotic such as *aripiprazole (Abilify), *olanzapine (Zyprexa) or *quetiapine (Seroquel).

Polypharmacy is likely to produce more side effects, less adherence, and increased cost to the patient. Switching to a different monotherapy antidepressant is the best choice in the majority of cases.[1-4]
*Adding second generation antipsychotics as adjuncts is not superior to switching to a different antidepressant or combination antidepressant therapy, yet poses significant metabolic risk (weight, lipids, and glucose increases) and other risks (TD, cardiac), that must be considered.[4] These medications may decrease a patient's adherence to a medication regimen possibly resulting in less robust outcomes than expected. The second generation antipsychotics are also considerably more expensive than the alternative approaches outlined above.

When treating geriatric patients, the above considerations are especially important since there are known hazards as published in the black box warnings regarding the safe use of second generation antipsychotics in this population.

We hope that you find this letter informative in your care of individuals diagnosed with major depression. Although this letter is not a comprehensive review article, we have attempted to provide you with the most current evidence-based information. We look forward to your continued collaboration with us in providing high quality, cost-effective care for our members.

Sincerely,

Mary Ellen Foti, MD
Deputy Commissioner
Clinical and Professional Services
Massachusetts Department of Mental Health

Paul L. Jeffrey, PharmD
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References

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3-Institute for Clinical Systems Improvement. Major Depression in Adults in Primary Care. Bloomington MN: Institute for Clinical Systems Improvement; 2009 May.

4-Connolly KR. Thase ME. If at First You Don't Succeed. A Review of the Evidence for Antidepressant Augmentation, Combination and Switching Strategies Drugs 2011; 71 (1): 43-64.

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