REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Inclusion of Antidepressants and Anti-Anxiety Drugs in the Virginia Medicaid Preferred Drug List (PDL) Program

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 60

COMMONWEALTH OF VIRGINIA
RICHMOND
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Introduction

Item 326 BB 7 of the 2004 Appropriations Act provides guidance to the Department of Medical Assistance Services (DMAS) regarding the potential inclusion of the antidepressant and anti-anxiety drug classes in the Department's preferred drug list (PDL) program. The Appropriations Act states that, if included on the PDL, these classes may not become effective earlier than July 1, 2005, and that DMAS must report to the Governor and General Assembly by January 1, 2005 on its plans for inclusion. Attachment A provides a copy of Item 326 BB 7.

DMAS' Pharmacy and Therapeutics (P&T) Committee's first meeting to review these classes occurred on October 6, 2004 and public comments from all interested stakeholders were accepted at this time. The P&T Committee unanimously recommended inclusion of these classes on the PDL. Subsequently, the Committee met on December 8, 2004 to determine which drugs within these classes would be "preferred." Subject to the approval of the 2005 General Assembly, the Department will include these classes on the PDL effective no earlier than July 1, 2005.

This report provides information regarding: (i) how the P&T Committee reviewed these drug classes and determined whether the classes should be added to the PDL; (ii) which drugs within each class are recommended to be "preferred;" (iii) the estimated annual savings of including these drug classes on the PDL; and (iv) the Department's plan for minimizing adverse impacts on consumers and educating providers.

Background Information on Virginia's Preferred Drug List (PDL)

Item 325 (ZZ1) of the 2003 Appropriations Act directed the Department to establish a PDL program no later than January 1, 2004. The PDL program was implemented in three phases throughout calendar year 2004. There were thirteen drug classes implemented in January, six classes in April and twelve in July. Attachment B provides an overview of the drug classes implemented in each of the three phases. Thus far in the implementation of the PDL, 31 of the top 50 drug classes (based on utilization and costs) have been incorporated into the program. In addition to the initial implementation phases, the P&T Committee has completed its annual review of the 13 Phase I classes for 2005. The Committee also has approved three additional classes for PDL inclusion outside of these phases: long acting narcotics (to be implemented January 17, 2005), antidepressants, and anti-anxiety medications.

The Department implemented a "Virginia-specific" program design and supplemental rebate process that is unique among other states. The PDL has been largely successful in terms of provider compliance, operations, supplemental rebates and stakeholder acceptance. Pharmacy providers and physicians were informed of changes as result of the PDL and other pharmacy program initiatives through Virginia Medicaid Memos prior to the implementation of each phase as well as during pharmacy training sessions held across the Commonwealth.

DMAS' Policy and Research Division has been conducting an ongoing analysis of the PDL program since its inception. The key findings of the most recent analysis (as of September 2004) are listed below.

- The PDL compliance rate, measured as the percent of patients being prescribed "preferred" drugs, exceeds the compliance level (85%) needed to achieve the necessary budget savings. While the compliance rate varies among the different drug classes, the overall compliance rate across all drug classes is 92%.

- There have been no clinical denials of medications as a result of the PDL prior authorization process. Since the beginning of the program, 76% of all requests for prior authorization have been granted; for the remaining 24%, the prescribing physician voluntarily switched to the preferred drug. There have only been technical denials for retrospective payments to long-term care facilities that have already dispensed the medication but did not comply with the appropriate PDL processes. Therefore, there is no evidence that any patient has been denied access to their medications as a result of this program.

- Market share of PDL drug classes has significantly shifted as a result of the program. In September 2004, preferred drugs accounted for 89% of all claims in PDL classes compared to 61% in January 2004 (prior to the PDL Program). This market shift indicates an acceptance among providers of the drugs available as "preferred," and supports the achievement of program savings.

- Evaluation results show the average cost per prescription has decreased below the projected amount since PDL implementation. In addition, the actual pharmacy expenditures are significantly below the Department's official forecast. These comparisons of actual versus forecasted expenditures indicate the program is meeting the targeted level of savings required in the Appropriations Act. Savings are driven principally by a supplemental rebate process that has worked very well (overall, manufacturers have provided competitive pricing) and the high PDL compliance rate (92%). The most recent savings estimates completed by First Health Services Corporation (FHSC), DMAS' PDL contractor, indicate annual savings for FY 2005 to be approximately $15.2 million in general funds (GF). While the original savings estimate in the 2003 Appropriations Act was $18.0 million (GF), this estimate assumed $2.5 million (GF) in savings related to the antidepressants and anti-anxiety drug classes being on the PDL. Because these classes have not yet been added to the PDL, the FHSC savings estimate indicates the program is meeting its targeted savings.

Description of the Antidepressant and Anti-Anxiety Drug Classes

Antidepressants

Antidepressants are used to treat a variety of diseases including but not limited to: major depressive disorder, moderate and minor depressive disorders, obsessive-compulsive disorder, moderate to severe bulimia nervosa, and a variety of panic disorders. The antidepressant drug class can be divided into three sub-classes because of their pharmacological properties: Selective Serotonin Reuptake Inhibitors (SSRIs), New Generation Antidepressants and Tricyclic Antidepressants. The antidepressant agents all appear effective in the treatment of depression.

On September 14, 2004, an advisory panel with the Food and Drug Administration (FDA) voted 15-8 to recommend that all antidepressants include a "black box" warning, the strongest warning issued by the government, to inform consumers that the medications can cause suicidal thoughts and behavior in patients younger than age 18. FDA officials reported that an analysis of 15 clinical trials, some of which were not made public for years, found a "consistent link" between the use of antidepressants and suicidal tendencies in children. In response to the FDA warnings, some pediatricians and family physicians have decided not to prescribe antidepressants to children and have begun to refer parents who seek the medications to child and adolescent psychiatrists.

Anti-Anxiety Medications

Anti-anxiety agents are used in the management of anxiety disorders and provide short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anti-anxiety agents may produce psychological or physical dependence. As a result, these drugs have been categorized by the Drug Enforcement Agency (DEA) as Schedule IV controlled substances, which have less abuse potential than Schedule III substances and limited dependence liability. In terms of cost, all the drugs in this drug class have generic equivalents readily available in the market place. Unless there is a patient-specific allergy or adverse reaction, the generic equivalent is both clinically efficacious and the most cost-effective choice.

Table 1 provides the most recent six months of Virginia Medicaid data on the various mental health drug classes including total payment, claims, and number of recipients.

Table 1

Statistics on Virginia Medicaid's Mental Health Drugs

6 months claims data: 5/1/2004 – 10/31/2004

Category Name	Total Payment	Total Claims	Total unique recipients
SSRIS	$13,627,261	190,664	56,066
New Generation Antidepressants	$ 6,675,283	113,607	35,665
Antidepressants-Tricyclics	$ 444,690	37,976	12,044
Anti-Anxiety Drugs	$ 4,221,370	204,069	57,632
Total	**$24,968,604**	**546,316**	**161,407***

**Recipients can be in more than one category (note median age of recipients on these drugs is 52)*

P&T Committee Process For Reviewing Antidepressant and Anti-Anxiety Medications for Possible Inclusion in the PDL

As noted previously, the P&T Committee held two meetings to review the antidepressant and anti-anxiety drug classes; one on October 6, 2004, and the other on December 8, 2004. In addition to the two psychiatrists on the P&T Committee, the Committee also consulted with a Board-Certified Psychiatric Pharmacist to assist in the review of these drug classes.

At the October 6, 2004, meeting, the P&T Committee conducted a clinical review of the antidepressant and anti-anxiety drug classes as well as received public comments from drug manufacturers, clinicians, mental health advocates and other interested parties. There were presentations from representatives of the Psychiatric Society of Virginia, the Mental Health Association of Virginia, the Virginia Association of Community Services Boards, and the National Alliance for the Mentally Ill as well as a practicing pediatrician, pharmacist, psychiatrist, patient advocate, and a mental health patient. The P&T Committee also requested, received and reviewed written comments from various interested parties in advance of the meeting.

The issues addressed by the stakeholders included: a strong desire to keep open access to all antidepressant and anti-anxiety drugs; concerns about the potential impact of switching between different drugs within the class; and the need for special considerations for pediatric patients. One group stated that not enough research has been done in this area and also suggested that there are many conflicting clinical studies. They strongly recommended exempting children from the PDL for these classes. In addition, they recommended grandfathering or exempting patients who have been stabilized on any antidepressant or anti-anxiety medications. In many cases when treating a patient for depression and/or anxiety, multiple medication trials are necessary and physicians need all the choices available to find the right drug for their specific patient.

The Committee also received correspondence from Delegate Phillip A. Hamilton, Chairman of the House Committee on Health, Welfare, and Institutions, asking that antidepressants be addressed cautiously with the best interest for patient care and safety in mind. Delegate Hamilton urged the Committee to fully examine the inclusion of behavioral health drugs on the PDL and consider all implications before implementing any restrictions on medications for the treatment of mental illness.

At the conclusion of the October 6th meeting, the Committee voted unanimously that the antidepressant and anti-anxiety drug classes should be included in the PDL so long as certain patient protections are included, an appropriate number of "preferred" drugs are available, and key clinical issues are addressed. As a result of the Committee's decision, FHSC initiated supplemental rebate negotiations with each pharmaceutical manufacturer. (Patrick Finnerty, DMAS Director, sent a status report to the General Assembly summarizing the actions taken by the P&T Committee regarding the antidepressant and anti-anxiety drug classes on October 7, 2004. A copy of the report is provided at Attachment C.)

During its meeting on December 8th, five speakers all representing antidepressant pharmaceutical manufacturers presented additional clinical material to the P&T Committee. In addition, the Committee also reviewed confidential financial information on the drug classes (i.e., supplemental rebate offers) that was developed by FHSC. During this meeting, the Committee made its decision on the drugs within each class that would be designated as "preferred." The P&T Committee's overall approach is to have broad access to the various drugs in each class. Attachment D provides the list of "preferred" drugs for these classes. Almost all of the drugs within these classes were included on the PDL with the exception of some brand name drugs whose generic equivalents are preferred. The P&T Committee's approach will greatly reduce the number of patients who would have to change their current drug therapy, and will ensure patient access to drugs to minimize adverse impacts on consumers. For the non-preferred drugs that do not have generic equivalents, fewer than 300 patients would be required to obtain prior authorization or switch to a preferred drug.

In addition, the Committee decided to carve out the Selective Norepinephrine Reuptake Inhibitors (SNRIs) from the New Generation antidepressant class and review these separately at their upcoming March meeting. This was done to allow time for additional research of clinical and financial information for these drugs. There are only 2 SNRIs in the antidepressant class, Cymbalta and Effexor. In addition, the Committee decided it would like to review these drug classes again within the next twelve months.

States' Policies Regarding Mental Health Medications

At the request of the P&T Committee, the Department and FHSC completed a survey of other states' policies regarding mental health medications. This information was presented at the December 8th P&T Committee meeting. All fifty states were contacted and thirty-nine states responded. Of those states, twenty-six currently have a PDL in place. Among the states with existing PDLs, the following information was collected:

- Nine states have legislation that prohibits either antidepressants and/or anti-anxiety medications from being included on their PDL
- Fourteen states have SSRIs on the PDL
- Fifteen states have at least one of the classes (antidepressants or anti-anxiety medications) on their PDL
- Five states have neither antidepressants nor anti-anxiety medications on their PDL

Estimated Savings of Including Antidepressant and Anti-Anxiety Drugs on the Virginia Medicaid PDL

Including the antidepressants and anti-anxiety drug classes in the PDL program would generate annual estimated savings of $600,000 in general funds (GF) or $1.2 million total funds. This estimate is based on six months (May-October, 2004) of actual paid claims for Virginia Medicaid, and FHSC's projections for supplemental rebates only with no market share movement. Given the large number of "preferred" drugs on the PDL in these classes and the multiple trials of different drug therapies that are common when treating depression, no significant market share shifts are anticipated. This estimated savings amount is mainly attributed to the SSRI class and the New Generation Antidepressant class. There are virtually no savings achieved from the anti-anxiety class because the drugs in this class are mostly available generically and there are no associated supplemental rebates. It is important to note that 3 of the 5 brand name SSRIs (Celexa, Paxil and Prozac) have generic equivalents and the other 2 (Lexapro and Zoloft) will be coming soon; Zoloft in 2006 and Lexapro in 2009. Once all the products have generic equivalents, the class will be similar to the anti-anxiety class and will produce very little supplemental rebate savings.

The estimated annual savings ($600,000 GF) are substantially lower than the previous estimate of $2.5 million GF. The lower level of savings is due to the extensive list of "preferred" drugs in each class. Substantially higher savings (i.e., at or near the earlier estimate of $2.5 million GF) are possible; however, this would require that fewer drugs be designated as "preferred." In these scenarios, a far greater number of patients would have to be switched to a different drug than they currently are taking.

Implementation Work Plan

The 2004 Appropriations Act requires DMAS to present a plan on how it will minimize adverse impacts on consumers, and ensure appropriate provider education. As previously noted, the P&T Committee's approach to including the antidepressant and anti-anxiety drug classes in the PDL program is to provide broad access to these drugs by designating a large number of drugs in each class as "preferred." This approach ensures that very few consumers will need to switch to another drug. Accordingly, the potential adverse impact on consumers will be negligible.

With respect to provider education, the Department would use the same approach to informing the provider community about the antidepressant and anti-anxiety drug classes as the initial phases of the PDL. Information will be communicated to the provider community through a Medicaid Memo, the Department's web site and other communication techniques, as necessary, in June 2005. This includes targeted communications with mailings to Pharmacists, Physicians, Advocacy Groups, Community Services Boards, and State Mental Health agencies. The Department would coordinate implementation with the Virginia Pharmacists Association, the Virginia Association of Community Services Boards, the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS), and various other provider associations. The Department also would utilize its PDL Implementation Advisory Group to assist in communicating information to consumers and providers.

Soft edits (messaging only) would begin on June 1, 2005. These messages alert pharmacists when a non-preferred drug is dispensed that a prior authorization (PA) will be needed the next time the prescription is filled. This also allows the pharmacist to inform the client of the PA requirement in advance of the next refill. On July 1, 2005, the PA requirement (hard edit) for non-preferred drugs that were not selected to be on the PDL would be implemented. A message regarding PA would be returned when a non-preferred drug is dispensed.

Other Department Initiatives Regarding Mental Health Drugs

DMAS is currently considering a Behavioral Management Program separate from the PDL which would be administered by Comprehensive Neuroscience, Inc. (CNS). The PDL saves money through market share movement to lower net cost drugs and supplemental rebates; the behavioral management program would improve quality of care and save money through improving the prescribing habits of physicians by peer education of best practices. The CNS program would perform an intensive and specialized retrospective drug utilization review of specific prescription medications (antidepressants, antipsychotics and anti-anxiety drugs) used in the treatment and management of mental illness. This program is supported by the Virginia Psychiatric Society, and would be funded using an educational grant from Eli Lilly and Company. DMAS is working with DMHMRSAS on this project.

It is important to note that this program is mutually exclusive from the PDL and that both programs can operate simultaneously. The program works by identifying prescribers with unusual prescribing habits of mental health drugs for educational interventions such as letters, educational material, and direct contact from peer prescribers. The goal is to educate prescribers about best practices in patient care. CNS uses a decision support system driven by a data trend analysis to identify areas of improvement. The prescribers would be identified based on patient patterns of use that differ from established medical criteria. Currently, fifteen other states have contracted with CNS for similar programs and their initial results in improving quality of care have proven quite positive.

Attachment A:
2004 Appropriations Act, Item 326 BB(7)

Item 326 BB 7. If the Department of Medical Assistance Services does not exempt antidepressants and antianxiety medications used for the treatment of mental illness from the Medicaid Preferred Drug List (PDL) program, it should defer inclusion of such drug classes from the PDL until July 1, 2005. Prior to including these drug classes in the PDL Program, the Department shall provide a plan for inclusion, which stipulates mechanisms to minimize adverse impacts on consumers, to ensure appropriate provider education that will promote effective prescribing practices that are medically indicated, and to ensure that inclusion is evidence-based, clinically efficacious and cost-effective. The Department shall report the plan to the Governor and Chairman of the House Appropriations and Senate Finance Committees and the Joint Commission on Health Care by January 1, 2005.

Attachment B:

Drug Classes Included in Each Phase of PDL Implementation

Phase I Drug Classes ~ January 5, 2004

- Proton Pump Inhibitors
- Nasal Steroids
- Non-Sedating Antihistamines and combination products
- Histamine-2 Receptor Antagonists
- Inhaled Beta Adrenergics
- COX-2 Inhibitors
- Inhaled Steroids
- HMG-CoA Reductase Inhibitors (Statins)
- Sedative Hypnotics
- Angiontensin Converting Enzyme Inhibitors and combination products
- Angiotensin Receptor Antagonists and combination products
- Beta blockers
- Dihydropyridine Calcium Channel Blockers
- Non-Dihydropyridine Calcium Channel Blockers

Phase II ~ April 1, 2004

- Oral Hypoglycemics (Second Generation Sulfonylureas, Alpha Glucosidase Inhibitors, Biguanide Combinations, Hypoglycemic, Biguanide Type, Meglitinides, hiazolidinediones -- TZDs)
- Leukotriene Modifiers
- Analgesic- NSAIDS (non-steroidal anti-inflammatory drugs)
- Serotonin Receptor Agonists
- Onychomycosis Antifungals
- Bisphosphonates for Osteoporosis

Phase III ~ July 1, 2004

- Carbonic Anhydrase Inhibitors – Opthalmic
- Alpha 2 Adrenergics – Opthalmic
- Beta-blockers – Opthalmic
- Prostaglandin Inhibitors – Opthalmic
- Antihyperkinesis/CNS Stimulants (Medications For ADD/ADHD)
- Macrolides - Adult (Antibiotics)
- Macrolides - Pediatrics (Antibiotics)
- 2nd Generation Quinolones - Systemic (Antibiotics)
- 3rd Generation Quinolones - Systemic (Antibiotics)
- 2nd Generation Cephalosporins (Antibiotics)
- 3rd Generation Cephalosporins (Antibiotics)

Attachment C:

October 7, 2004 Memorandum Regarding P&T Committee's Review of Antidepressants and Anti-Anxiety Drugs

(See four page document immediately following this attachment)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 7, 2004

MEMORANDUM

TO: Members of the Health and Human Resources Subcommittee
House Appropriations Committee

Members of the Health and Human Resources Subcommittee
Senate Finance Committee

Members of the Joint Commission on Health Care

FROM: Patrick W. Finnerty

SUBJECT: Status Report on Preferred Drug List: Review of Antidepressants and Antianxiety Medications

As you know, Item 326 BB(7) of the 2004 Appropriations Act provides that if antidepressants and antianxiety medications used in the treatment of mental illness are not exempted from the preferred drug list (PDL), the Department of Medical Assistance Services (DMAS) should defer inclusion of these drug classes in the PDL until July 1, 2005. In addition, the Appropriations Act language requires that prior to including these drug classes in the PDL, a plan must be submitted to the Governor and the General Assembly by January 1, 2005 outlining what steps will be taken to minimize adverse impacts on consumers, educate providers, and ensure that inclusion in the PDL is evidenced-based, clinically efficacious, and cost-effective. I have enclosed a copy of Item 326 BB(7) for your review.

I am writing to provide a status report on the actions taken by the Pharmacy & Therapeutics (P&T) Committee regarding these drug classes. The P&T Committee met yesterday to review antidepressants (including SSRIs) and antianxiety drugs, and to receive public comment from mental health advocates and others. Among the P&T Committee members present at the meeting were the Committee's two psychiatrists and a physician who is the President of the National Patient Advocate Foundation. The Committee also consulted with a Board-Certified Psychiatric pharmacist who helped review and discuss various clinical issues associated with these drug classes.

The P&T Committee received and reviewed written comments from various interested parties and heard oral testimony from several speakers, including representatives of the Psychiatric Association of Virginia, the National Alliance for the Mentally Ill (NAMI), the Mental Health Association of Virginia, and practicing psychiatrists. Among the issues raised by those who addressed the Committee were: (i) a strong desire to keep open access to all of the various antidepressant and antianxiety drugs, (ii) concerns about the potential impact of switching between different drugs within the classes, and (iii) the need for special considerations for pediatric patients.

Following the public comment period, the P&T Committee reviewed clinical information on the drug classes as well as a summary of the literature that contains the results and findings of clinical studies. The Committee then held extensive discussions about various clinical issues, including those raised during the public comment period. Specific issues discussed by the P&T Committee included: (i) the advisability of having several "preferred" drugs in each class, (ii) the potential need to include a "grandfathering" provision such that patients who currently are taking a medication would not have to switch to a different drug, and (iii) the potential need to have special considerations for pediatric patients. The Committee also discussed the benefits of other quality improvement programs such as that sponsored by Eli Lilly and Comprehensive NeuroScience, Inc. (CNS). Administering this type of program would be complementary with the PDL. (Several other states, including Missouri and Indiana, have implemented the Lilly/CNS program. DMAS currently is working with Eli Lilly and CNS who have offered to implement this program in Virginia at no cost to the Commonwealth. The Psychiatric Association of Virginia, which supports this approach, also has been involved in these discussions.)

At the conclusion of its discussion, the P&T Committee voted unanimously that the antidepressants and the antianxiety drugs are "PDL-eligible." This means the P&T Committee believes that with appropriate clinical criteria to address the concerns raised during the meeting (e.g., number of "preferred" drugs, grandfathering, special considerations for pediatric patients, etc.), these drug classes can be included in the PDL. Deciding that a drug class is "PDL-eligible" is just the first step in the process of including a drug class within the PDL. The most critical step in the process is the next step at which time the Committee determines what the clinical criteria should be and how many drugs would be "preferred" in each class. These discussions will take place at the Committee's next meeting, which we anticipate will be scheduled for late November. Please remember that at no time would Medicaid patients be denied access to a drug that their physician determines is needed.

As with all other drug classes that have been reviewed and determined by the P&T Committee to be "PDL-eligible," First Health Services (DMAS' PDL contractor) will now contact the manufacturers of the drugs in these classes to seek supplemental rebate offers. At the next P&T Committee meeting, the members will review the supplemental rebate offers, develop their recommended clinical criteria, and recommend which drugs would be "preferred" in each class. These actions will enable us to submit a detailed report to the Governor and the General Assembly by January 1, 2005.

I want to emphasize that the actions taken thus far and the next steps in the process of reviewing these drug classes are being taken by DMAS and its P&T Committee with the full understanding that no actions to implement any of these recommendations will occur until July 1, 2005. We fully recognize that the General Assembly wants to review these recommendations during its 2005 legislative session to ensure it is agreeable with our approach and/or to make any changes it deems appropriate.

Should you have any questions regarding this matter, please do not hesitate to contact me. I may be reached at (804) 786-8099. In addition, complete information on the entire PDL program and other pharmacy initiatives can be found at the DMAS website: www.DMAS.virginia.gov. Thank you.

/pwf

Enclosure

cc: The Honorable Jane H. Woods
Members of the Pharmacy and Therapeutics Committee
Members of the Board of Medical Assistance Services
Joe Flores
Susan Massart
Kim Snead
William Murray

Department of Medical Assistance Services

2004 Virginia Acts of Assembly
Special Session I
Chapter 4

Item 326

BB.7. If the Department of Medical Assistance Services does not exempt antidepressants and antianxiety medications used for the treatment of mental illness from the Medicaid Preferred Drug List (PDL) program, it should defer inclusion of such drug classes from the PDL until July 1, 2005. Prior to including these drug classes in the PDL Program, the Department shall provide a plan for inclusion, which stipulates mechanisms to minimize adverse impacts on consumers, to ensure appropriate provider education that will promote effective prescribing practices that are medically indicated, and to ensure that inclusion is evidence-based, clinically efficacious and cost-effective. The Department shall report the plan to the Governor and Chairman of the House Appropriations and Senate Finance Committees and the Joint Commission on Health Care by January 1, 2005.

Attachment D:

Proposed Preferred Drug List for Antidepressants and Anti-Anxiety Medications

Preferred	Non-Preferred
Antidepressants – SSRIs	
ZOLOFT	CELEXA (generic preferred)
LEXAPRO	PAXIL (generic preferred)
FLUOXETINE HCL	PROZAC WEEKLY
PAROXETINE HCL	PROZAC (generic preferred)
PAXIL CR	SARAFEM (generic preferred)
PEXEVA	
CITALOPRAM	
New Generation Antidepressants*	
TRAZODONE HCL	WELLBUTRIN SR (generic preferred)
MIRTAZAPINE	REMERON TAB RAPDIS (generic preferred)
WELLBUTRIN XL	REMERON TABLET (generic preferred)
BUPROPION HCL TABLET SA	SERZONE (generic preferred)
MIRTAZAPINE TAB RAPDIS	WELLBUTRIN (generic preferred)
BUDEPRION SR	DESYREL (generic preferred)
BUPROPION HCL	
NEFAZODONE HCL	
MAPROTILINE HCL	
TRAZODONE	
Anti-anxiety Drugs	
ALPRAZOLAM	XANAX (generic preferred)
LORAZEPAM	KLONOPIN TABLET (generic preferred)
LORAZEPAM INTENSOL	ATIVAN (generic preferred)
DIAZEPAM	VISTARIL (generic preferred)
BUSPIRONE HCL	KLONOPIN TAB RAPDIS
CHLORDIAZEPOXIDE HCL	BUSPAR (generic preferred)
OXAZEPAM	TRANXENE T-TAB (generic preferred)
CLORAZEPATE DIPOTASSIUM	VALIUM (generic preferred)
XANAX XR	TRANXENE SD
MEPROBAMATE	LIBRIUM (generic preferred)
HYDROXYZINE PAMOATE	SERAX (generic preferred)
HYDROXYZINE HCL	ATARAX (generic preferred)
CLONAZEPAM	
Tricyclic Antidepressants	
AMITRIPTYLINE HCL	SURMONTIL
NORTRIPTYLINE HCL	ASENDIN (generic preferred)
DOXEPIN HCL	TOFRANIL-PM (generic preferred)
IMIPRAMINE HCL	VIVACTIL
CLOMIPRAMINE HCL	PAMELOR (generic preferred)
DESIPRAMINE HCL	ANAFRANIL (generic preferred)
AMOXAPINE	SINEQUAN (generic preferred)
MAPROTILINE HCL	ELAVIL (generic preferred)
	TOFRANIL (generic preferred)
	LUDIOMIL (generic preferred)

**SNRIs (Effexor and Cymbalta) will be reviewed by the P&T Committee in March 2005*