Depression Screening in the Primary Care Setting

Depression is a common and prevalent issue among most age groups which often accompanies many other physical health maladies. Screening for depression in multiple health care settings (e.g., Primary Care) has become more common and continues to be very important. For example, at Capital BlueCross, members who are assessed by our Case Management and Disease Management Staff are also screened for depression. Those who screen positive for depressive symptoms are encouraged to seek further assessment and treatment, when warranted and appropriate. Along these lines, Capital BlueCross continues to encourage screening for depression in the primary care setting, as well as encouraging appropriate treatment for depression.

Attached to this Alert is a “Tip” sheet developed by our Behavioral Healthcare Vendor, Magellan Behavioral Health®, Inc. The Tip sheet includes information regarding treatment for depression as well as information regarding making referrals to a Behavioral Healthcare Specialist when deemed necessary by a Primary Care Practitioner.

Although improving, stigma and shame continue to accompany behavioral health problems (depression included) and, at times, individuals are reluctant to acknowledge these problems without being directly asked. Given this, practitioners in primary care play a key role, not only in treating depression, but also in screening for depression as well.

On behalf of Capital BlueCross, Magellan Behavioral Health®, Inc. assists in the administration of behavioral health benefits. Magellan Behavioral Health is an independent company.
Substance Use Disorders Identification Tip Sheet

Screening
Among the best clinical settings for early screening, detection and intervention of substance use disorders are primary care offices, trauma centers, and emergency rooms. Members with positive screens obtained through any of the following methods should be further evaluated. For the initial screening, the primary care or other clinician can:

- **Administer a substance use screening tool**, such as the Alcohol Use Disorders Identification Test (AUDIT), AUDIT-C (Consumption) or the CAGE-AID. The first three questions of the AUDIT can be used alone to detect up to 80 percent of patients with mild to moderate alcohol use problems. The Audit-C, a three-item modified version of the AUDIT instrument, screens for frequency of alcohol consumption, quantity of alcohol consumption, and the quantity of alcohol consumption on a single occurrence. The four-item CAGE alcohol use questionnaire is the most popular screening test used in primary care. The CAGE-AID expands the focus of each item of the CAGE to include both alcohol and other drugs and identifies severe alcohol and drug use problems, including dependence. (AUDIT and CAGE can be accessed at http://pubs.niaaa.nih.gov/publications/aa65/AA65.htm.)

- **Administer a single-question screen**:
  
  “When was the last time you had more than four drinks (women) or five drinks (men) in one day?”
  
  Up to 86 percent of those with alcohol-use problems can be identified with this question. A positive result is “one or more times in the past three months.”

- **Look for warning signs suggesting substance use disorders**, including repeated complaints of physical discomfort, elevated vital signs, frequent accidents, sleep disturbances, fatigue and unintentional weight loss.

- **Assessing adolescents**: Signs of substance use disorders in adolescents may include involvement in the juvenile justice system, truancy or poor grades, diminished interests in hobbies or sports, irritability, lying, carelessness about appearance, family conflict, injuries requiring emergency room visits, etc. When alcohol use is a problem in adolescents, illegal drug use is 11 times more likely to also be a problem. The CRAFFT test was developed specifically for screening adolescents. (Access at http://www.netwellness.org/healthtopics/substanceabuse/crafft.cfm.)

- **Assessing older adults**: Substance use disorders in older adults are under-diagnosed. One in three older adults who abuse alcohol develops the problem after age 60. Older adults require less alcohol to become intoxicated, and can easily hide problematic alcohol use due to lower demands for social and occupational functioning.

Treatment

- A recent systematic review and meta-analysis for the U.S. Preventive Services Task Force found that behavioral counseling interventions improve alcohol consumption with brief multicontact interventions (i.e., 10-15 minute per contact) delivered by a primary care provider, a nurse or health educator. In another study, a single discussion on the risks of alcohol abuse, goal setting for cutting back, and one follow-up discussion reduced alcohol consumption by 30 percent and occasions of binge-drinking over a 12-month period.

- Pharmacotherapy interventions can be helpful during all phases of treatment (see Table). Medications are best used in combination with psychotherapy or counseling interventions. Medication-Assisted Treatment (MAT) has been shown to be effective in the treatment of alcohol dependence with Food and Drug Administration (FDA)-approved drugs (e.g., disulfiram, naltrexone, acamprosate) and treatment of opioid dependence with methadone, naltrexone and buprenorphine.

- For adolescents and patients on methadone maintenance, family therapy has demonstrated effectiveness.

- Psychosocial treatment emphasizing social support is effective for older adults at risk of relapse due to loneliness and social isolation.

- Self-help groups such as Alcoholics Anonymous (www.alcoholics-anonymous.org), Narcotics Anonymous (www.na.org) and Al-anon (www.al-anon.alateen.org) can be helpful.
References


<table>
<thead>
<tr>
<th>Name</th>
<th>Indications</th>
<th>Prescribing (Starting dose, range, baseline labs)</th>
<th>Advantages</th>
<th>Risks</th>
</tr>
</thead>
</table>
| Disulfiram (Antabuse)       | Helps prevent relapse of alcohol abuse. Ingested in combination with alcohol, it causes nausea, vomiting, headache and flushing. | **Induction:** 250-500 mg QD for 2 weeks.  
**Maintenance:** 250 mg QD. Range is 125-500 mg QD.  
**Labs:** liver function tests (LFT) initially, then at 10-14 days, every six months thereafter. | Useful in patients with a history of relapse, current motivation, and a witnessed ingestion program. | Metallic after-taste; dermatitis; severe reaction or death could result from alcohol ingestion. |
| Naltrexone (Revia)          | Helps with alcohol cravings, possibly by reducing the reinforcing effects of alcohol. Also used to block the effects of opiates. | **Induction for opiate dependence:** Be sure patient is opioid-free for 7-10 days; confirm by urine drug screen (UDS). Start 25 mg. If no withdrawal reaction, increase by another 25 mg. Continue at 50 mg QD.  
**Induction for alcohol dependence:** Start at 50 mg QD. Continue at 50 mg QD. | Very useful in the acute recovery phase of alcohol dependence (first 12 weeks). | Nausea; abdominal pain; constipation; dizziness; headache; anxiety; fatigue. |
| Vivitrol™ (naltrexone for extended-release injectable suspension) | Vivitrol™ is used for the treatment of alcohol dependence and for the prevention of relapse following opioid detoxification. | **Vivitrol™:** Be sure patient is alcohol-free for at least a week. IM dose – 380 mg q 4 weeks.  
**Labs:** UDS, LFTs prior to induction and every six months thereafter. | Vivitrol™ may be easier for patients recovering from alcohol dependence to use consistently. The once-monthly formulation addresses the critical problem of adherence in the opioid addicted population. Also addresses problems encountered with substitution therapy – i.e., access, acceptability, diversion, illicit use and overdose deaths. | Vivitrol™ should not be used by a patient who is also using opioids such as heroin or opioid analgesics. |
| Acamprosate (Campral)       | Helps with alcohol cravings, possibly by reducing intensity of prolonged withdrawal syndrome. Benefit emerges after 30 to 90 days. | **Induction:** Begin two 333 mg tablets, tid.  
**Maintenance:** 333 mg, tid.  
**Labs:** blood urea nitrogen (BUN), creatinine, creatinine-clearance. | Reasonably safe in patients with mild to moderate hepatic impairment (excreted via the kidneys). | Diarrhea and increased libido. |
<table>
<thead>
<tr>
<th>Name</th>
<th>Indications</th>
<th>Prescribing (Starting dose, range, baseline labs)</th>
<th>Advantages</th>
<th>Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Topiramate</strong>&lt;br&gt;(Topamax)</td>
<td>Helps patients reduce drinking, avoid relapse to heavy drinking, achieve and maintain abstinence, or gain a combination of these effects. (Note: the FDA has not approved the drug for this indication.)</td>
<td><strong>Induction:</strong> Initial dose 25 mg at bedtime. Increase dose by 25-50 mg daily each week, divided into morning and evening doses.&lt;br&gt;<strong>Maintenance:</strong> Target dose is 200 mg per day total, but patients unable to tolerate that dose may respond to lower doses.&lt;br&gt;<strong>Labs:</strong> Monitor renal function, serum electrolytes and bicarbonate.</td>
<td>Can be used in patients who are still drinking.</td>
<td>Paresthesias; taste perversion; anorexia and weight loss; somnolence; cognitive dysfunction.</td>
</tr>
<tr>
<td><strong>Baclofen</strong>&lt;br&gt;(Lioresal, Kemstro)</td>
<td>Baclofen has shown promise in initial clinical trials for treating severe alcohol dependence. Baclofen is administered to patients who have already become abstinent.&lt;br&gt;There is also some empirical evidence that baclofen is comparable to diazepam in reducing uncomplicated alcohol withdrawal symptoms.</td>
<td><strong>Induction:</strong> Begin 5 mg tid for the first three days and then to a ceiling dosage of 10 mg tid.&lt;br&gt;<strong>Maintenance:</strong> Continue 10 mg tid.&lt;br&gt;<strong>Labs:</strong> aspartate aminotransferase (AST), alkaline phosphatase or glucose levels for patients with liver diseases or diabetes mellitus.</td>
<td>Particularly well suited for patients with liver impairment as it is excreted primarily through the kidney.</td>
<td>Common adverse side effects: headaches, insomnia, nausea, hypotension, urinary frequency. Rare side effects include visual abnormalities and excitement.</td>
</tr>
<tr>
<td><strong>Buprenorphine Hydrochloride</strong>&lt;br&gt;(Subutex)</td>
<td>Can be used for office-based detoxification from opiates and maintenance treatment for opiate dependency by specially trained and registered physicians.</td>
<td><strong>Induction:</strong> Begin 8 mg SL on day one, 16 mg day two.&lt;br&gt;<strong>Maintenance:</strong> Continue 16 mg SL QD thereafter. Range is 4-24 mg QD.&lt;br&gt;<strong>Labs:</strong> UDS at induction, and monthly thereafter. LFTs on induction, every six months thereafter.</td>
<td>Buprenorphine can prevent symptoms of withdrawal in patients addicted to opiates; an alternative maintenance treatment to methadone.</td>
<td>Dizziness; nausea; respiratory depression.</td>
</tr>
<tr>
<td><strong>Buprenorphine Hydrochloride and Naloxone Hydrochloride</strong>&lt;br&gt;(Suboxone)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


These guidelines are not intended to replace a practitioner’s clinical judgment. They are designed to provide information and to assist practitioners with decisions regarding care. The guidelines are not intended to define a standard of care or exclusive course of treatment. Health care practitioners using these guidelines are responsible for considering their patients’ particular situation in evaluating the appropriateness of these guidelines.

This information is not a statement of benefits. Benefits may vary and individual coverage will need to be verified by the Plan.
**Assessing and Managing the Suicidal Patient: Keeping the Patient Safe**

**When Should an Assessment Be Conducted?**
- At intake on any patient with a psychiatric complaint, history of non-suicidal self-injuries, previous suicide attempt, mental illness diagnosis or substance use disorder
- When a patient experiences sadness, low mood, recent loss or hopelessness or having no purpose
- When a patient acts anxious, agitated, or reckless or shows rage and talks about seeking revenge
- When patient displays extreme mood swings
- At each subsequent session as long as the patient remains at risk
- Any time a patient has any other identified potential risk factors.

Each assessment while the patient remains at risk must be documented and include:
- Findings
- Risk factors
- Interventions to contain, manage and mitigate risk.

**What Are the Elements for Assessing Suicide?**
There are two elements to assess:
- Elicitation of suicidal ideation
- Identification and weighing of risk factors.

**How Do I Assess Ideation and Risk?**
At minimum, ask directly for presence and nature of suicidal thoughts.
- Determine frequency and circumstances; characterize thoughts as passive ideation ("I would be better off dead") or active ideation with a plan ("I am planning to shoot myself")
- Make use of available assessment tools, e.g., the Scale for Suicide Ideation (SSI), Beck Scale for Suicide Ideation (BSS) or Columbia-Suicide Severity Rating Scale (C-SSRS)
- Determine if there is current intent or a plan
- Ask for plan details, including rehearsals
- Determine if there's a history of thoughts, wishes, impulses, self-injuries or suicide attempts
- Assess availability and lethality of means
- Assess attitude, beliefs and values about suicide
- Ask patient about barriers to suicide, reasons for living and dying
- Consider and be sensitive to the different cultural views regarding suicide
- Determine if anything is different this time that will raise or lower risk
- Determine if patient shared ideation with anyone
- Identify any support person who might be helpful in reducing the risk.

**How Do I Weigh Risk Factors?**
Patients are at greater risk for suicide if they have/are:
- Psychiatric hospitalization within the past year
- More than one risk factor, increasing risk of suicide
- Been recently discharged from inpatient psychiatric unit, emergency department, or from residential addiction treatment
- Experienced discontinuities in treatment and fragmentation of care
- Actively psychotic
- Depression and/or substance use disorder; bipolar disorder, alcohol and other substance use disorder; schizophrenia; dementia; borderline personality disorder; psychopathology with psychotic symptoms, dementia accompanied by neuropsychiatric symptoms of depression
- Depressive disorders accompanied by anxiety
- Been noncompliant with medication treatment for schizophrenia
- Had lithium treatment discontinued, especially when abrupt discontinuation
- Had a recent or impending loss
- Stressful life events
- Recent separation or divorce
- A history of impulsive or self-destructive behavior
- Committed violence in the past year
- Access to guns
Assessing and Managing the Suicidal Patient: Keeping the Patient Safe

- Past suicidal behavior or have previously attempted suicide
- A family history of suicide
- Socially isolated
- Victims of cyber bullying or other social messaging
- A chronic, terminal or painful medical disorder
- Of advanced age, i.e., aged 45 years or older
- Newly diagnosed with serious medical problems
- Male aged 65 or older
- Lost a child either to suicide or in early childhood
- A history of physical or sexual abuse in childhood
- Homosexual, bisexual, transgender youth
- Diagnosis of HIV-AIDS
- Social disconnectedness and are elderly

How Do I Manage the Suicidal Patient?
When risk appears severe and imminent, a medical emergency requires immediate containment and intensive medical treatment, usually in a psychiatric hospital setting with close observation. Take direct, appropriate action by calling 911 for emergency services or contact Magellan.

If risk does not appear severe and imminent:
- Mitigate, eliminate risk factors
- Strengthen barriers and reasons for not committing suicide
- Develop outpatient safety plans, including a family support plan
- Establish a therapeutic alliance
- Treat underlying disorder or contact Magellan
- Address any abuse of substances.

What Are the Top High-Risk Diagnoses for Completed Suicides?
- Depression, especially with psychic anxiety, agitation and/or significant insomnia
- Bipolar disorder
- Alcohol and other substance use disorders
- Schizophrenia
- Borderline personality disorder
- Psychotic symptoms accompanied by psychopathology
- Dementia accompanied by neuropsychiatric symptoms of depression and over the age of 60.

© 2004-2014 Magellan Health, Inc. Adapted from: Magellan Behavioral Health Practice Guideline for Assessing and Managing the Suicidal Patient, this tip sheet has been produced to provide assistance to psychiatrists and other mental health professionals, and to primary care physicians, in evaluating the potentially suicidal patient. Comprehensive review of the guideline is recommended.
Assessing and Managing the Suicidal Patient: Keeping the Patient Safe

Adolescent

What Are the Elements for Assessing Adolescent Suicide?
♦ Elicitation of suicidal ideation—purpose, isolation, premeditation
♦ Identification and weighing of risk factors—consider subjective factors (expected outcomes) and objective factors (planning activities).

How Do I Assess Ideation and Risk in Adolescent Patients?
(See Adult Tip Sheet)

How Do I Weigh Risk Factors?
Adolescent patients are at greater risk for suicide if they have/are:

Girls:
♦ Depression and/or substance use disorder
♦ Attempted suicide or self-harm previously
♦ ADHD (inattentive type with no medical treatment).

Boys:
♦ Attempted suicide or self-harm previously
♦ Depression and/or substance use disorder
♦ Disruptive behavior
♦ Anger/ aggression/impulsive behavior.

All:
♦ Stressful psychosocial life events
♦ Psychotic symptoms with existing psychopathology
♦ Received treatment with SSRIs (however, findings have shown that overall, the risk/benefit for SSRI use in pediatric depression appears to be favorable with careful monitoring)
♦ Poor communication with their parents/family conflict
♦ Poor self-esteem/feelings of inferiority
♦ Feelings of incompetence
♦ Recent history of suicide of friend, sibling or other family member
♦ Feelings of being responsible for negative events (such as parents’ divorce)
♦ A history of physical and/or sexual abuse
♦ A history of and/or current self-mutilation
♦ Isolation from peers; deterioration in appearance/dress
♦ Struggles with gender identity issues
♦ Suicide contagion - suicide in school or peer group
♦ Victims of child abuse
♦ Victim of cyber bullying or other form of social messaging
♦ Homosexual, bisexual or transgender.

What Are the Top High-Risk Diagnoses for Completed Suicides?
(See Adult Tip Sheet)

How Do I Manage the Adolescent Suicidal Patient?
When risk appears severe and imminent, a medical emergency requires immediate containment and intensive medical treatment, usually in a psychiatric hospital setting with close observation. Take direct, appropriate action by calling 911 for emergency services or contact Magellan.

If risk does not appear severe or imminent:
♦ Evaluate ideation, intent and plans more frequently
♦ Re-frame the suicide attempt as unsuccessful problem-solving
♦ Enlist parents/family as allies
♦ Educate parents about suicide
♦ Instruct parents to take suicidal statements seriously and limit access to any lethal means.


© 2004-2014 Magellan Health, Inc. Adapted from: Magellan Behavioral Health Practice Guideline for Assessing and Managing the Suicidal Patient, this tip sheet has been produced to provide assistance to psychiatrists and other mental health professionals, and to primary care physicians, in evaluating the potentially suicidal patient. Comprehensive review of the guideline is recommended.
Treating Depression in the Primary Care Setting

The Centers for Disease Prevention and Control (CDC) estimates that nearly 8 percent of Americans age 12 years and older report current depression. In the U.S., major depressive disorder affects nearly 20 percent of adults at least once during their lifetime. Although depression can be a devastating illness, the majority of those diagnosed with major depression can be effectively treated. However, many people suffering from depression either do not realize they have an illness that can be treated or do not believe that treatment works.

Research has shown that a majority of Americans who seek help for depression, or symptoms of depression, will initiate care with their primary care physician (PCP) rather than a mental health professional. Effective collaboration of care between PCPs and behavioral health providers is a key element in the successful treatment of depression.

Co-Occurrence with Medical Illnesses
The risk of depression is often higher in individuals with serious medical conditions. For example, depression occurs in up to 33 percent of patients who have experienced a heart attack; affects 12 to 24 percent of people with diabetes; occurs in about 15 to 25 percent of people with cancer, depending on the type; and impacts almost half of stroke survivors. Treatment of depression may have a beneficial effect on the overall functioning and recovery and rehabilitation process of the physically ill individual.

Treatment
About two-thirds of people who suffer from major depression can achieve a full remission of symptoms. However, this may require from one to four treatment steps, i.e., specific episodes of treatment. Also, the chances of reaching remission are higher for the first and second treatment steps than for subsequent steps. The most common treatments are antidepressant medication, psychotherapy or a combination of the two. As with many illnesses, early treatment is more effective and helps prevent the likelihood of serious recurrences.

According to the American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients with Major Depressive Disorder, Third Edition:

- Factors to consider in choosing a first-line antidepressant medication include: anticipated side effects and their safety or tolerability, a history of prior response in patient or family member, patient preference, cost, potential drug interactions, co-occurring psychiatric or general medical conditions, relative efficacy and effectiveness, and half-life.
- Monoamine Oxidase Inhibitors (MAOIs) are generally reserved for patients who do not respond to other treatments. Also, the guideline notes that Selective Serotonin Reuptake Inhibitors (SSRIs) or MAOIs may be considered for patients with atypical symptoms.
Improvement with pharmacotherapy can be observed after four to eight weeks of treatment. If at least moderate improvement is not noted after four to eight weeks of pharmacotherapy, a reappraisal of the treatment regimen should be done.

The goals of acute phase treatment for major depressive disorder are to induce remission of symptoms and to achieve a full return to the patient’s baseline levels of symptomatic and functional status.

During 16 to 20 weeks following remission, patients who have been treated with antidepressant medications in the acute phase should be maintained with these agents to prevent relapse. During the continuation phase, the treatment should be at the same dose, intensity and frequency as in the acute phase. Both the APA Guideline and the Institute for Clinical Systems Improvement (ICSI) Health Care Guideline: Major Depression in Adults in Primary Care, Thirteenth Edition, recommend long-term maintenance treatment with antidepressants in order to prevent relapse and recurrence of depression. The APA Guideline states that the treatment that was effective in the acute and continuation phases should be used in the maintenance phase. The ICSI Guideline specifies that the dosage of antidepressant drug resulting in a therapeutic response should be the dose that is used for the maintenance phase, i.e., six to 12 months for the first depressive episode, three years for the second episode, and indefinitely for a second episode with complicating factors or for a third/subsequent episode. Complicating factors for depression may include rapid recurrence of episodes, advanced age (over 60 years) at onset of major depressive episode, severity and family history.

### Antidepressants and Suicide

Clinical evidence strongly supports the use and effectiveness of antidepressant medications in the treatment of depression in all age groups. However, concerns have surfaced about the safety of such usage in children and adolescents. In 2004, after reviewing reports of clinical trials, the Food and Drug Administration (FDA) concluded that more children and teens taking antidepressant medications reported that they spontaneously thought about suicide or made a suicide attempt than those in that age group receiving placebos. As a result, the FDA directed manufacturers to include a warning on all antidepressants and expanded warning statements to clinicians.

After the issuance of the *black box warning* for all antidepressants for patients under 18 years of age, there was a precipitous drop of 25 percent in rates of both diagnosis and treatment of depression by pediatric and non-pediatric primary care physicians. A later meta-analysis, conducted by an FDA committee, of 24 clinical trials including nine antidepressants (n=4,400) in the pediatric population found a very small increase (0.7 percent) in risk of suicidal thinking/behavior, but no increase in completed suicides. More data showed that apprehension about the use of antidepressants in the pediatric population created a barrier to treatment, resulting in a corresponding 25 percent increase in completed suicide rate in children. The American Academy of Child and Adolescent Psychiatry (AACAP) currently recommends that “through careful monitoring, the development of a safety plan and the combination of medication with psychotherapy, the risks for increased suicidal thoughts can be managed. For moderate to severe depression, there is benefit in the use of medication because of a higher rate of relief, and more complete relief, from depressive symptoms than not using any medication.” The AACAP considered the available evidence from other studies and concluded that, while spontaneously reported suicide events are more common with SSRI treatment, the benefits of SSRI use in pediatric depression outweigh the risks if carefully monitored. The AACAP also acknowledges that further study is required.

Physicians involved in the care of children and adolescents taking antidepressants should be alert to warning signs of possible increased suicidality and take prompt action if any adverse effects are observed. When the patient has a history of suicidality, such monitoring should occur at every session—and patients who miss appointments should be contacted by the clinician. Further, clinicians should inform patients and their families about specific risks and warning signs.
Switching antidepressants to non-monoamine oxidase inhibitor antidepressants, i.e., tricyclic or tetracyclic, selective serotonin reuptake inhibitor, dopamine-norepinephrine reuptake inhibitor, serotonin-norepinephrine reuptake inhibitor, serotonin modulator, or norepinephrine-serotonin modulator antidepressants, within the same class or to another class is usually done when patient improvement is not seen after an adequate trial. After this, combination and augmentation strategies may be attempted with a non-monoamine oxidase inhibitor antidepressant or another adjuvant agent, e.g., lithium, atypical antipsychotics, thyroid hormone, anticonvulsants, psychostimulants. Beginning psychotherapy, changing the type of psychotherapy or increasing the frequency of the psychotherapy sessions may also be considered for these patients.

**When treating a depressed patient in the primary care setting, it is critical that patients be monitored closely over time to ensure an adequate medication trial and to prevent treatment drop-out.**

**Referral**
In most situations, the PCP’s best decision may be to refer the treatment-resistant patient to a psychiatrist for specialized psychopharmacologic treatment and/or psychotherapy. Other referrals may be made to a behavioral health practitioner or facility, e.g., suicide or homicide risk, psychotic or severe unipolar/bipolar depression, specialized therapy.

**Getting Help**
Call the behavioral health telephone number on the member’s health insurance card.

**More Information**
For references and more extensive information on the etiology and treatment of major depression, see Magellan’s *Clinical Practice Guideline on the Assessment and Treatment of Patients with Depressive Disorders* available at [www.MagellanHealth.com/provider](http://www.MagellanHealth.com/provider) under Providing Care/Clinical Guidelines.

---

These guidelines are not intended to replace a practitioner’s clinical judgment. They are designed to provide information and to assist practitioners with decisions regarding care. The guidelines are not intended to define a standard of care or exclusive course of treatment. Health care practitioners using these guidelines are responsible for considering their patients’ particular situation in evaluating the appropriateness of these guidelines. This information is not a statement of benefits. Benefits may vary and individual coverage will need to be verified by the Plan.