MEDICAL POLICY

POLICY TITLE	**ESKETAMINE (SPRAVATO™)**
POLICY NUMBER	**MP 2.367**

CLINICAL BENEFIT	☒ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**1/1/2025**

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I. POLICY

Treatment-Resistant Depression

Esketamine (Spravato™) nasal spray may be considered **medically necessary** for treatment-resistant depression when the following conditions are met:

Initial Administration For 28 Days:

- Individual is 18 years of age or older; **and**
- Individual meets the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) criteria for a major depressive episode (See Table 1) by a structured clinical interview for DSM-5 disorders; **and**
- Individual current depressive episode is moderate or severe depression based on either of the following:
  - Montgomery-Asberg Depression Rating Scale (MADRS) ≥ 28 (see policy guidelines); or
  - Hamilton Rating Scale for Depression (HAM-D) score ≥ 17 (see policy guidelines); **and**
- Individual meets the following:
  - Has tried and had an inadequate response to two antidepressant agents from 2 different antidepressant classes (i.e., selective serotonin reuptake inhibitors, serotonin and norepinephrine reuptake inhibitors, tricyclic antidepressants, bupropion, or mirtazapine). An adequate trial of an antidepressant is defined by **BOTH** of the following:
    - The trial length was at least 6 weeks at generally accepted doses or of sufficient duration as determined by the treating physician at the generally accepted doses; **and**

    - Individual was ≥80% adherent to the agent during the trial; **and**
- Individual is to receive esketamine (Spravato™) nasal spray in conjunction with an oral antidepressant **and**
- Individual does not have current substance use disorder unless in remission (complete abstinence for a month); **and**
- Individual does NOT have any Food and Drug Administration (FDA) labeled contraindications to the requested agent and esketamine (Spravato™) nasal spray is intended to be used consistently with the FDA approved label (see policy guidelines) including meeting Spravato Risk Evaluation and Mitigation Strategy (REMS) program requirements (see policy guidelines); **and**
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., psychiatrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis.

Major Depressive Disorder with Acute Suicidal Ideation or Behavior

Esketamine (Spravato™) nasal spray may be considered **medically necessary** for the treatment of major depressive disorder with acute suicidal idealtion or behavior when the following conditions are met:

Initial Administration For 28 Days:

- Individual is 18 years of age or older; **and**
- Individual meets the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) criteria for a major depressive episode (See Table 1) by a structured clinical interview for DSM-5 disorders; **and**
- Individual current depressive episode is moderate or severe based on either of the following scales:
    - Montgomery-Asberg Depression Rating Scale (MADRS) ≥ 28 (see policy guidelines); **or**
    - Hamilton Rating Scale for Depression (HAM-D) score ≥ 17 (see policy guidelines); **and**
- Individual is currently hospitalized and is at a imminent risk for suicide as documented by:
    - Individual response to a structured assessment for suicidal ideation indicative of imminent risk of suicide (see policy guidelines); **and**
    - Confirmation of imminent risk of suicide by clinical assessment by a mental health professional/psychiatrist (see policy guidelines)
- Individual is to receive esketamine nasal spray in conjunction with standard-of-care treatment based on clinical judgment and practice guidelines that may be comprised of oral antidepressant(s), an atypical antipsychotic, or a mood stabilizer.
- Individual does NOT have any U.S. Food and Drug Administration (FDA) labeled contraindications to the requested agent and esketamine (Spravato™) nasal spray is intended to be used consistently with the FDA approved label (see policy guidelines)

including meeting Spravato Risk Evaluation and Mitigation Strategy (REMS) program requirements (see policy guidelines).

- The prescriber is a specialist in the area of the patient's diagnosis (e.g., psychiatrist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis.

Subsequent Administration For Up To 1 Year:

Esketamine (Spravato™) nasal spray may be considered **medically necessary** for reauthorized for up to one (1) year if when the following conditions are met:

- Individual has had improvement in depression symptoms as evaluated with an appropriate depression rating scale (e.g., Patient Health Questionnaire -9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item, MADRS, HAM-D); **and**
- Individual is to receive esketamine (Spravato™) nasal spray in conjunction with an oral antidepressant **and**
- Individual does not have current substance use disorder; **and**
- Individual does NOT develop any FDA labeled contraindications to the requested agent and esketamine (Spravato™) nasal spray is intended to be used consistently with the FDA approved label (see policy guidelines) including meeting Spravato REMS program requirements (see policy guidelines).

Esketamine (Spravato™) nasal spray is considered **investigational** in all other situations, as there is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure.

POLICY GUIDELINES

A treatment session for use of esketamine (Spravato™) nasal spray must ensure the following:

- Treatment is administered under the direct supervision of a healthcare provider.
- Blood pressure is assessed before and after treatment to ensure safety in accordance with the FDA label.
- Individual receiving treatment should be advised to avoid food for at least 2 hours before administration and to avoid drinking liquids at least 30 minutes prior to administration.
- Individual receiving treatment should be advised to avoid use of nasal corticosteroid or nasal decongestant one hour prior to treatment.

  Individual is monitored for at least 2 hours at each treatment session, followed by an assessment to determine when the patient is considered clinically stable and ready to leave the healthcare setting.

For treatment-resistant depression, the recommended adult dosage of esketamine (Spravato™) nasal spray during the induction and maintenance phases are as follows:

- Induction phase (weeks 1-4): Administer twice per week with day 1 starting dose at 56 mg and subsequent doses at 56 mg or 84 mg. Evidence of therapeutic benefit should be evaluated at the end of the induction phase to determine need for continued treatment.
- Maintenance phase (weeks 5-8): Administer once weekly doses at 56mg or 84mg. Starting week 9 and after, administer every 2 weeks or once weekly doses at 56mg or 84mg. Dosing frequency should be individualized to the least frequent dosing to maintain remission/response.

For the treatment of adults with major depressive disorder with acute suicidal ideation or behavior, the recommended adult dosage of esketamine nasal spray is 84 mg twice per week for 4 weeks. Dosage may be reduced to 56 mg twice per week based on tolerability. The use of esketamine nasal spray beyond 4 weeks has not been systematically evaluated.

Esketamine (Spravato™) nasal spray is contraindicated in patients with following conditions:

- Aneurysmal vascular disease (including thoracic and abdominal aorta, intracranial and peripheral arterial vessels) or arteriovenous malformation.
- Intracerebral hemorrhage.
- Hypersensitivity to esketamine, ketamine, or any of the excipients.

Spravato Risk Evaluation and Mitigation Strategy (REMS)

Spravato (esketamine) is available only through a restricted program under a REMS called the Spravato REMS because of the risks of serious adverse outcomes from sedation, dissociation, and abuse and misuse.

Important requirements of the Spravato (esketamine) REMS include the following:

- Healthcare settings must be certified in the program and ensure that Spravato is: – Only dispensed in healthcare settings and administered to patients who are enrolled in the program; and
- Administered by patients under the direct observation of a healthcare provider and that patients are monitored by a healthcare provider for at least 2 hours after administration of SPRAVATO [see Dosage and Administration]; and
- Pharmacies must be certified in the REMS and must only dispense Spravato to healthcare settings that are certified in the program.

Further information, including a list of certified pharmacies is available at www.SPRAVATOrems.com.

In order to mitigate these risks, it is available only through the restricted program above, called the Spravato REMS. The essential features of this program include:

- Esketamine (Spravato™) nasal spray is only dispensed and administered to patients in a medically supervised healthcare setting that monitors these patients.
- Pharmacies and healthcare settings that dispense esketamine (Spravato™) nasal spray are certified.
- Ensuring that each patient is informed about the serious adverse outcomes resulting from sedation and dissociation and need for monitoring.
- Enrollment of all patients in a registry to further characterize the risks and support safe use

Montgomery–Asberg Depression Rating Scale (MADRS)

MADRS is commonly used to evaluate the efficacy of antidepressant by assessing the severity of depression. It contains 10 items and the total score ranges from 0 to 60. The following cut-offs were proposed to classify the level of depression severity:

- 0-6: No depression (absence of symptoms)
- 7-19: Mild depression
- 20-34: Moderate depression
- 35-60: Severe depression

Hamilton Rating Scale for Depression (HAM-D)

HAM-D is a 17-item rating scale to determine the severity level of depression in a patient before, during, and after treatment. The total score ranges from 0 to 52, with the score corresponding to the following classifications:

- 0-7: No depression (normal)
- 8-16: Mild depression
- 17-23: Moderate depression
- ≥24: Severe depression

Cross-reference:

MP 1.042 Deep Brain Stimulation
MP 2.092 Cranial Electrotherapy Stimulation (CES) and Auricular Electrostimulation
MP 2.264 Genetic Testing for Diagnosis and Management of Mental Health Conditions

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross please see additional information below, and subject to benefit variations as discussed in Section VI below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:

III. DESCRIPTION/BACKGROUND

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Treatment-resistant depression

Patients with either major depressive disorder or bipolar disorder can present with depressive episodes (See Table 1). Depression that does not respond satisfactorily to treatment is generally referred to as treatment-resistant depression (TRD). Approximately one in three patients with depression are considered treatment resistant. A recent systematic review identified 155 different definitions for treatment resistant depression; however, many had overlapping criteria and/or were a clinician's opinion rather than a validated definition. While there is no standardized definition of treatment-resistant depression, the generally accepted definition is failure of two or more antidepressant treatment attempts with an adequate dose and duration. Majority of systematic reviews and guidelines or consensus statements report that the commonly used definitions were based on treatment of patients whose depression failed to respond (a decrease in depressive severity of at least half) or did not go into remission (complete recovery as measured by a score on a depressive severity instrument below a threshold) following two or more treatment attempts of an adequate dose and duration. Experts do not agree on how to define adequate dose and adequate duration, although the minimum duration cited is typically 4 weeks.

Lack of consensus on definition of treatment-resistant depression limit the ability of systematic reviewers or other experts to synthesize information and generalize treatment-resistant depression findings to the array of patient populations encountered in daily practice. According to the Technology Assessment by Agency for Healthcare Research and Quality (AHRQ) on defining treatment-resistant depression in the Medicare population, lack of clear definition for treatment-resistant depression have made translating research findings or systematic reviews into clinical practice guidelines challenging and inconsistent. As a result, guideline definitions of treatment-resistant depression differ, agreement on what constitutes prior treatment adequacy is lacking, and recommended "next step" interventions can diverge.

According to the AHRQ Report, there are no validated, standard diagnostic tools for treatment-resistant depression. Diagnosis of a major depressive episode or bipolar disorder can be made through a standard clinical evaluation using Diagnostic and Statistical Manual of Mental Disorders (DSM), International Classification of Diseases (ICD), or through a structured clinical assessment tool: Hamilton Depression Rating Scale, Montgomery-Asberg Depression Rating Scale (See Policy Guidelines). Subsequently, treatment history may be elicited by a clinical interview (e.g., the number of prior pharmacologic attempts of adequate dose and duration that did not produce remission) or administering a structured, staging tool (Antidepressant Treatment Response Questionnaire, Thase Rush Staging Model, Massachusetts General Hospital Staging Model, or the Maudsley Staging Model) to confirm treatment resistance. No preferred approach exists, and careful history has not been compared directly with a structured tool.

Table 1. Diagnostic Criteria for a Major Depressive Episode

	Criteria	
A	Five or more symptoms for 2 weeks (one of which must be either depressed mood or anhedonia)	1. Depressed mood most of the day nearly every day 2. Anhedonia most of the day nearly every day 3. Significant weight loss or gain 4. Insomnia or hypersomnia 5. Psychomotor agitation or retardation 6. Fatigue or loss of energy 7. Feelings of worthlessness or excessive guilt 8. Diminished ability to think or concentrate; indecisiveness 9. Recurrent thoughts of death; suicidal ideation or attempt
B	Symptoms cause clinically significant distress or functional impairment	
C	The episode is not attributable to the physiological effects of a substance or another medical condition	
D	The episode is not better explained by a psychotic illness	
E	There has never been a manic or hypomanic episode	

Adapted from Diagnostic and Statistical Manual of Mental Disorders: DSM-5. 5th ed., American Psychiatry Association, 2013.

Major Depressive Disorder and Suicidal Ideation/Behavior

In a community survey conducted in 21 countries with over 100,000 individuals by World Health Organization, 12-month prevalence of suicidal ideation (thoughts) was approximately 2 percent, and that the lifetime prevalence was 9 percent. Reported annual prevalence of suicidal ideation in US adults is 4 percent7. Psychiatric illness is strongly associated with risk of suicide, and major depressive disorder is the psychiatric diagnosis most commonly associated with suicide. The reported prevalence of suicidal ideation in adult patients with MDD is as high as 60%, and the lifetime incidence of attempted suicide in this population ranges between 10% and 20%. Further, the lifetime risk of completed suicide has been estimated to be 3.4% in this population.[1]

Patients with major depressive disorder who have active suicidal ideation with intent constitute a psychiatric emergency as the time between the onset of suicidal ideation and suicide attempt is often very short. These patients are often hospitalized to protect them from self-harm, although the benefits of hospitalization are often temporary. Moreover, while standard antidepressants effectively treat depressive symptomatology, including suicidal ideation, they require 4–6 weeks to exert their full effect,[6] limiting their utility in crisis situations.

Current Treatment

Prior to the approval of esketamine (Spravato™), olanzapine-fluoxetine combination was the only U.S. Food and Drug Administration (FDA) approved drug for treatment resistant depression. Strategy for managing treatment resistant depression generally involves modifying current antidepressant therapy or augmenting existing therapies with non-antidepressant medications (such as atypical antipsychotics). Modification strategies include use of higher

dose, switching to a new antidepressant, or adding on to an existing therapy. The adequate duration of antidepressant therapy is usually minimum of 6 weeks. Additional 4 to 6 weeks may be required for patients who show partial response.

For patients with long-standing treatment-resistant depression who do not benefit from treatment modification or augmentation strategies are referred to as refractory depression. For these patients, other strategies such as electroconvulsive therapy, repetitive transcranial magnetic stimulation, vagus nerve stimulation techniques have been used with limited success. Depression-focused psychotherapy may be added to pharmacotherapy but is generally not considered stand-alone therapy for refractory depression. Off-label treatments include drugs from multiple classes (antipsychotics, lithium, thyroid hormone, ketamine), often in combination with antidepressants.

Regulatory Status

On March 6, 2019, esketamine (Spravato™) nasal spray was approved by the U.S. Food and Drug Administration for the treatment of treatment-resistant depression in adults.

On July 31, 2020, esketamine (Spravato) nasal spray received an approval for supplemental indication for the treatment of depressive symptoms in adults with major depressive disorder with acute suicidal ideation or behavior.

IV. RATIONALE

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Summary of Evidence

Treatment-Resistant Depression

For individuals with treatment-resistant depression who receive esketamine (Spravato™), the evidence includes 4 randomized, double-blind, placebo-controlled trials. The relevant outcomes are change in disease status, quality of life, treatment-related mortality, and treatment-related morbidity. The 4 randomized controlled trials (TRANSFORM-1, -2 and -3 and SUSTAIN-1) with placebo comparators enrolled more than 700 patients across studies. Of the 4 randomized controlled trials, TRANSFORM-2 and SUSTAIN-1 were the basis for regulatory approval in the United States. While both trials used flexible esketamine dosing, the objective of TRANSFORM-2 was to assess short-term (4 week) efficacy of esketamine while SUSTAIN-1 aimed to assess durability of treatment effect over the long-term (event-driven study with no fixed duration). Results of TRANSFORM-2 showed that trial met the primary endpoint with a 4-point difference (95% CI -7.3 to 0.6) in least square mean difference of Montgomery-Asberg Depression Rating Scale (MADRS) total score in favor of esketamine. The magnitude of treatment effect observed in TRANSFORM-2 was within the range observed in clinical trials for other approved antidepressants currently on the market. Assessment of time course of response showed that treatment effect was apparent at 24 hours, remained consistent through end of 4 week with no further separation between groups after day 2. Results of the SUSTAIN trial showed that patients who received at least 16 initial weeks of treatment with esketamine and achieved clinical remission or response were less likely to relapse if they continued esketamine vs being switched to placebo (hazard ratio=0.49 for remitters and hazard ratio=0.30 for responders

respectively). Results of TRANSFORM-1 (a fixed-dose study) and TRANSFORM-3 (flexible-dose study in patient's ≥ 65 years of age) did not reach statistical significance for the primary endpoint. Limitations included possibility of unblinding due to patients' perception of treatment assignment influenced by acute subjective dissociative effects of esketamine that could bias the results. Further, there is limited generalizability of trials results. More than 90% of patients enrolled in the trials were Caucasians while it is known that depression is also common among other racial and ethnic minorities. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

Major Depressive Disorder with Acute Suicidal Ideation or Behavior

For individuals with major depressive disorder with acute suicidal ideation or behavior who receive esketamine, the evidence includes 2 randomized, double-blind, placebo-controlled trials. Relevant outcomes are change in disease status, quality of life, treatment-related mortality, and treatment-related morbidity. The 2 identical randomized controlled trials (ASPIRE-1 and -2) with placebo comparators enrolled 449 adults' patients with moderate-to-severe major depressive disorder who had active suicidal ideation. The primary objective was to assess short-term (24-hour after first dose) efficacy of esketamine. Results showed that both trials met the primary endpoint with approximately a 4-point difference in least square mean difference of MADRS total score in favor of esketamine. As per the FDA, statistically significant response results on the MADRS can likely be considered clinically meaningful. The magnitude of treatment effect observed in trials was within the range observed in clinical trials for other approved antidepressants currently on the market. Assessment of time course of response showed that treatment effect was apparent at 24 hours and remained fairly consistent through day 25 with no further separation between groups after day 2. Limitations included possibility of unblinding due to patients' perception of treatment assignment influenced by acute subjective dissociative effects of esketamine that could bias the results. Further, there is limited generalizability of trials results. More than 90% of patients enrolled in the trials were Caucasians while it is known that depression is also common among other racial and ethnic minorities. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

V. DEFINITIONS

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PATIENT HEALTH QUESTIONNAIRE NINE ITEM (PHQ-9) - the standard among scales for monitoring symptoms of depression. The PHQ-9 consists of only nine items that correspond to the nine DSM-5 criteria for unipolar major depression, as well as an additional item assessing psychosocial impairment. The PHQ-9 has been used in national and regional programs in the United States and United Kingdom that are intended to demonstrate the value of monitoring treatment of depression. In addition, the PHQ-9 has been translated into many languages and is used internationally. The scale is brief and should take less than two minutes to complete. The PHQ-9 has good test-retest reliability, internal consistency, and sensitivity to change in depression over time. It has been extensively studied as a screening measure for major depression in primary care settings.

Compound symptom criteria are assessed with a single item. As an example, the PHQ-9 assesses insomnia and hypersomnia with a single item, and likewise, reduced, or increased appetite. Thus, the nine-item format makes it easier to apply the DSM-5 diagnostic algorithm for major depression, though at a cost of some information for the purpose of monitoring response to treatment.

The patient is instructed to rate each symptom item on a four-point Likert scale, indicating how often they have been bothered by the symptom over the past two weeks (0 = not at all, 1 = several days, 2 = more than half the days, 3 = nearly every day). Total scores range from 0 to 27. A score of 0 to 4 indicates no depression, 5 to 9 mild depression, 10 to 14 moderate depression, 15 to 19 moderately severe depression, and a score of 20 to 27 indicates severe depression.

CLINICALLY USEFUL DEPRESSION OUTCOME SCALE (CUDOS)- contains 18 items assessing all of the DSM-5 criteria for unipolar major depression, as well as psychosocial impairment and quality of life. Compound DSM-5 symptom criteria referring to more than one construct (e.g., insomnia or hypersomnia) are subdivided into their separate components. It usually takes less than two minutes to complete the scale. The CUDOS has good test-retest reliability, internal consistency, sensitivity to change, and can be used to screen for depression. The patient is instructed to rate the symptom items on a five-point Likert scale indicating how well the item describes the patient during the past week (0 = not at all true/0 days; 1 = rarely true/ one to two days; 2 = sometimes true/ three to four days; 3 = usually true/ five to six days; 4 = almost always true/ every day). Total symptom scores on the scale range from 0 to 64, and empirically derived severity score ranges are 0 to 10 non-depressed, 11 to 20 minimal depression, 21 to 30 mild depression, 31 to 45 moderate depression, and 46 to 64 severe depression.

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY SELF REPORT 16 ITEM (QIDS-SR16) - multiple choice questions with four choices. The items cover the symptoms of DSM-5 unipolar major depression, including single items that are used to assess indecisiveness and impaired concentration, guilt, and worthlessness, and wishes for death and suicidal ideation. It usually takes 5 to 10 minutes to complete the scale. The QIDS-SR16 has good internal consistency, correlates significantly with clinician ratings of depression severity, and is sensitive to change. In scoring the QIDS-SR16, the highest score is used of the four items that assess sleep disturbance (initial, middle, and terminal insomnia; and hypersomnia), the two items that assess psychomotor disturbance (agitation and retardation), and the four items that assess appetite and weight disturbance. Total scores on the scale range from 0 to 27, and scores of 0 to 5 indicate no depression, 6 to 10 mild depression, 11 to 15 moderate depression, 16 to 20 severe depression, and 21 to 27 indicate very severe depression.

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member’s health benefit plan governs which services are covered, which are

excluded, which are subject to benefit limits, and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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This is a new treatment. This policy may be subject to change due to additional data, information and feedback received. Please check for updates.

Capital Blue Cross' medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Covered when medically necessary:

Procedure Codes					
J3490	G2082	G2083	S0013		

ICD-10-CM Diagnosis Code	Description
F32.0	Major depressive disorder, single episode, mild
F32.1	Major depressive disorder, single episode, moderate
F32.2	Major depressive disorder, single episode, severe without psychotic features
F32.4	Major depressive disorder, single episode, in partial remission
F32.5	Major depressive disorder, single episode, in full remission
F32.89	Other specified depressive episodes
F32.9	Major depressive disorder, single episode, unspecified
F32.A	Depression, unspecified

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ICD-10-CM Diagnosis Code	Description
F33.0	Major depressive disorder, recurrent, mild
F33.1	Major depressive disorder, recurrent, moderate
F33.2	Major depressive disorder, recurrent severe without psychotic features
F33.40	Major depressive disorder, recurrent, in remission, unspecified
F33.41	Major depressive disorder, recurrent, in partial remission
F33.42	Major depressive disorder, recurrent, in full remission
F33.8	Other recurrent depressive disorders
F33.9	Major depressive disorder, recurrent, unspecified

IX. REFERENCES

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X. POLICY HISTORY

TOP

MP 2.367	**01/31/2020 Major Review**. New Policy. Adopted from BCBSA, REMS critera included. Effective 7/1/2020.
	12/14/2020 Administrative Update. Code S0013 added. Effective 1/1/2021.
	01/04/2021 Minor Review. Added indication for adult patients with major depressive disorder with acute suicidal ideation or behavior; criteria must be met. Description background section and summary of evidence sections updated.
	09/01/2021 Administrative Update. New code F32.A added. Effective 10/1/21
	11/08/2022 Consensus Review. No change to policy statement. References updated.
	12/15/2023 Consensus Review. No change to policy statement. Updated background and references.
	09/12/2024 Consensus Review. No change to policy statement. Reviewed background and references.

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