Psychotropic Therapy During Pregnancy

Current evidence supports a comprehensive approach to treating psychiatric disorders in pregnant patients. While most literature support including psychotropic therapies as a component of this treatment approach, non-pharmacological methods (e.g. cognitive behavioral therapy) should be utilized to their fullest potential, due to the potential for pharmacological therapies to have increased risk of fetal harm in general. Additionally, there are psychotropics that could present greater risk of fetal harm than other; therefore, careful selection of these therapies and thorough patient counseling on the risks are required for pregnant patients. It is important to note that a general approach of withholding all medication therapies for the duration of pregnancy is strongly recommended against.

The American College of Obstetrics and Gynecology (ACOG) have recently published updated guidelines for the treatment and management of mental health conditions during pregnancy and the postpartum period. The following is a synopsis of the current recommendations for first-line pharmacotherapy selection for this patient population.

- ***For anxiety and depressive disorders***: Selective serotonin reuptake inhibitors (SSRIs) are preferred as first-line treatment with selective serotonin norepinephrine reuptake inhibitors (SNRIs) being a reasonable second-line treatment. Specifically, sertraline or escitalopram are preferred if no therapies have been tried previously.
- ***For bipolar disorders:*** Valproic acid should be avoided in the perinatal period; all other mood stabilizers that the patient has been stabilized on should be continued with a caveat that patients taking lithium in the first trimester should be screened with a detailed ultrasound in the second trimester and should have lithium levels checked regularly due to the small therapeutic window.

It is important to note that benzodiazepines particularly can pose a significant risk to both the pregnant patient and the fetus due to the significant central nervous system (CNS) depression. Therefore, it is recommended that both short-term and long-term use of benzodiazepines be minimized when possible. When necessary to use, especially in acute settings, the lowest effective dose is recommended along with careful titration and tapering to avoid withdrawal symptoms.

Overall, there are inadequate studies for many of the psychotropic therapies not mentioned above. Tricyclic antidepressants (with the exception of high doses of amitriptyline), atypical antidepressants (e.g., bupropion, mirtazapine, etc.), and antipsychotics (with the exception of olanzapine and quetiapine) have had few teratogenic effects reported but no robust placebo-controlled trials in pregnant patients performed. For add-on therapies and/or for disorders in which these therapies may be first line in non-pregnant patients, it is generally recommended to continue stable therapies that have no known increased risk in pregnancy with careful monitoring of both the pregnant patient and the fetus.

The American College of Obstetricians and Gynecologists (ACOG) guidelines can be found at the link:

https://www.acog.org/clinical/clinical-guidance/clinical-practice-guideline/articles/2023/06/treatment-and-management-of-mental-health-conditions-during-pregnancy-and-postpartum

Intervention Summary

The following table shows a summary of the proposed intervention topics and the number of potential patients that may be targeted by each intervention. The number of potential patients is based on the most recent ICER. The actual number of targeted patients for each intervention will be based on the ICER for the month the intervention is performed.

Outcomes assessment will be completed 180 days after the intervention is performed.

Proposed Intervention Topic	MCO	Pediatric (Age 18 and below)	Adult
1. Include patients (all ages) with a diagnosis of pregnancy in the last 30 days with psychotropic therapy that is not recommended for use in pregnancy (including selected tricyclic antidepressants, lithium, an/or valproic acid) for ≥ 30 days in the last 90 days. 2. Exclude patients with a diagnosis in the last 30 days that indicates the patient is no longer pregnant	**0**	**0**	**0**

References:

1. Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 5. Obstet Gynecol. 2023 Jun 1;141(6):1262-1288.
2. Betcher HK, Wisner KL. Psychotropic Treatment During Pregnancy: Research Synthesis and Clinical Care Principles. J Womens Health (Larchmt). 2020 Mar;29(3):310-318
3. Creeley CE, Denton LK. Use of Prescribed Psychotropics during Pregnancy: A Systematic Review of Pregnancy, Neonatal, and Childhood Outcomes. Brain Sci. 2019 Sep 14;9(9):235.

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[TODAY]

[adrs1]
[adrs2]
[adrs3]
[adrs4]

DEAR [tadrs1]:

In compliance with the OBRA '90 federal legislation, state Medicaid agencies are mandated to conduct Retrospective Drug Utilization Review Programs (RDUR). We hope that this retrospective DUR may assist you in optimizing your Medicaid patient's drug therapy. One way to achieve this goal is to identify potential drug therapy problems that may place patients at risk, particularly if multiple providers are identified. This RDUR program is informational in nature and allows you to incorporate the information provided into your continuing assessment of the patient's drug therapy requirements.

Current evidence supports a comprehensive approach to treating psychiatric disorders in pregnant patients. While most literature support including psychotropic therapies as a component of this treatment approach, non-pharmacological methods (e.g. cognitive behavioral therapy) should be utilized to their fullest potential, due to the potential for pharmacological therapies to have increased risk of fetal harm in general. Additionally, there are psychotropics that could present greater risk of fetal harm than other; therefore, careful selection of these therapies and thorough patient counseling on the risks are required for pregnant patients. It is important to note that a general approach of withholding all medication therapies for the duration of pregnancy is strongly recommended against.

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Provider Specific List of Patients on an SGA Who Have Not Had a Lipid Panel in the Past Year:
[namelist: last name, first name] [Recipient DOB]

The success of the DUR program is enhanced by the two way exchange of information. Therefore, at your convenience, we would appreciate learning of your assessment of this information and of any action taken in response to this notice. Although your participation in this program is voluntary, we find your feedback helpful in adjusting our program to address clinically important problems. *Please submit your response using the online provider response portal or complete the enclosed response form and fax it to (833) 470-0598. The online provider response portal can be accessed at https://forms.office.com/r/CXGEADqkRd or by scanning the QR code listed below.*

At the bottom of this letter are the specific prescriptions attributed to you by the dispensing pharmacy. In addition, if multiple prescribers are involved in the therapy mentioned above, each will receive this information. Thank you for your professional consideration.

Sincerely,
Medicaid Drug Use Review Board

References:

1. Treatment and Management of Mental Health Conditions During Pregnancy and Postpartum: ACOG Clinical Practice Guideline No. 5. Obstet Gynecol. 2023 Jun 1;141(6):1262-1288.
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PRESCRIBER RESPONSE

All information used to generate the enclosed letter, including Prescriber identification, was obtained from Pharmacy Claims Data. If there appears to be an error in the information provided, please note the discrepancy. Thank you for your cooperation. *As a reminder, the response can be submitted using the online provider response portal. The online provider response portal can be accessed at https://forms.office.com/r/CXGEADqkRd or by scanning the QR code listed below.*

1. This patient **is** under my care:

_____ I have reviewed the information and will continue without change.
_____ however, I did not prescribe the following medication(s)_____.
_____ and has an appointment to discuss drug therapy.
_____ however, has not seen me recently.
_____ however, I was not aware of other prescribers.
_____ I have reviewed the information and modified drug therapy.
_____ I have not modified drug therapy because benefits outweigh the risks.
_____ I have tried to modify therapy, however the patient refuses to change.
_____ I have tried to modify therapy, however symptoms reoccurred.

2. This patient **is not** under my care:

_____ however, I did prescribe medication while covering for other MD or in the ER.
_____ but has previously been a patient of mine.
_____ because the patient recently expired.
_____ and has never been under my care.

3. I have reviewed the enclosed information and found it:
_____ very useful_____ useful_____ neutral_____ somewhat useful_____ not useful.

4. Please check here if you wish to receive reference information on the identified problem___.(Please provide a fax number if available_____-_____-_____.)

Comments:
_____
_____
_____

[adrs1] Case# [case_no]
Letter Type [letter_type]
[alert_msg]
[criteria]

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