Behavioral Health Services (BHS)

Quick Guide: Parameters for the Use of Antidepressant Medications

Adult and Older Adult Behavioral Health

2026

Quick Guide

I. General Parameters for Use in Depressive and Bipolar Disorders

A. Definition:

Antidepressant medications in this parameter include: tricyclic antidepressants—{amitriptyline (Elavil), nortriptyline (Pamelor), doxepin (Sinequan)}, bupropion (Wellbutrin), trazodone, mirtazapine (Remeron), SSRIs—{(fluoxetine (Prozac), paroxetine (Paxil), fluvoxamine (Luvox), sertraline (Zoloft), citalopram (Celexa), escitalopram (Lexapro), vilazodone (Viibyrd), vortioxetine (Trintellix)(Brintellix)}, SNRIs—{duloxetine (Cymbalta), venlafaxine (Effexor), desvenlafaxine (Pristiq)}, and selected monoamine oxidase inhibitors—{isocarboxazid (Marplan), tranylcypromine (Parnate), selegiline (Emsam)}.

B. Essential Use:

1. Antidepressant medications should be considered during depressive mood episodes of moderate or severe intensity in patients with a diagnosis of:

    a) Major Depressive Disorder

    b) Bipolar I Disorder

    c) Bipolar II Disorder

    d) Schizoaffective Disorder, Depressive Type

2. Antidepressant medications should be continued for 6 to 12 months in treatment-responsive individuals with a diagnosis of major depressive disorder, single episode, in partial or complete remission, after which time a gradual taper could be considered and discussed with the patient.

3. Antidepressant medication should be tried in individuals with Persistent Depressive Disorder (PDD) who have not successfully responded to six months of treatment with psychotherapy alone or psychotherapy and other psychopharmacologic agents.

C. Optional Use:

1. Antidepressant medications may be tried in individuals with substance induced disorders with depressive features when detoxification from the responsible substance alone does not adequately resolve symptomatology or is not possible.

2. Antidepressant medications may be tried in individuals with depressive features due to a general medical condition when treatment of the responsible general medical condition alone does not adequately resolve symptomatology or is not possible.

3. Antidepressants may be tried for initial treatment in individuals with PDD.

4. Antidepressant medications may be continued for an indefinite period in treatment- responsive individuals with a diagnosis of major depressive disorders, recurrent, in partial or complete remission. Decisions regarding indefinite treatment should be informed by patient preference and the past course of the illness.

5. Antidepressant medications may be used for other disorders characterized by mood or affect disturbances only with appropriate additional justification in the medical record.

II. Use of Antidepressants Medications for Other Disorders

(Excluding use for anxiety disorders described in Parameters for the Use of Anxiolytic Medications)

A. Essential Use: SSRIs should be tried for treatment of bulimia nervosa.

B. Optional Use:

1. Bupropion and SNRIs may be used to treat ADHD when psychostimulant medications, guanfacine, clonidine, and atomoxetine are ineffective, contraindicated, or unavailable.

2. SSRIs may be used for obsessive-compulsive and related disorders such as trichotillomania and body dysmorphic disorder.

III. Multiple Concurrent Antidepressant Medications

Only one antidepressant medication should generally be used concurrently, but 2 may be used in exceptional circumstances; e.g., when trazodone is initially used to treat sleep disturbance in an individual whose depressive episode is likely to respond to a less sedating antidepressant; when bupropion is used to ameliorate sexual side effects from SSRIs; when one antidepressant is being tapered while another is being initiated; or when a patient fails to respond to numerous trials of monotherapy from multiple antidepressant classes.

IV. Use of Tricyclic Antidepressants and MAO Inhibitor(s)

A. Essential Use: Tricyclic antidepressants and MAOIs should be used when other antidepressant medications are contraindicated, ineffective or unavailable, or when patients are already stabilized and doing well on a tricyclic antidepressant or MAOI.

B. Contra-indications: Significant risk of untoward general medical effects relative to efficacy for tricyclic medications and MAOIs generally preclude their use as initial treatment except in unusual situations.

V. Use of Nefazodone

Nefazodone should not be used in any but the most exceptional cases, as the risks of hepatotoxicity generally outweigh any potential therapeutic benefits relative to other antidepressants.

VI. Use of Antidepressants in Major Depressive Disorder

A. SSRIs/SNRIs should be tried initially for treatment of major depressive disorder when no contraindications exist for their use.

B. Determination of which SSRI/SNRI should be used first is based upon availability, clinical judgment, presence of other general medical conditions, other concurrent medications, patient preference, and likelihood of adequate compliance.

C. When a non-tricyclic antidepressant is poorly tolerated or ineffective after an adequate clinical trial, the individual may be switched to a different antidepressant selected on the basis of clinical judgment.

D. When a second antidepressant is also poorly tolerated or ineffective after an adequate clinical trial, further trials with other antidepressants or augmentation strategies should be tried.

E. Selection of antidepressants for sequential trials should be based upon availability, clinical judgment, side effect profile, presence of other general medical conditions, other concurrent medications, patient preference, potential toxicity, and information regarding adequacy and outcome of previous treatment with other antidepressant medication. In general, it may be preferable to select antidepressants from classes with different mechanisms of action and/or metabolic pathways than those that have previously proved ineffective.

F. Special care must be taken to avoid serotonin syndrome by allowing 2 weeks between termination of an MAOI and initiation of a non- tricyclic medication.

G. No more than a 14-day supply of antidepressant medication should be provided when they are prescribed for individuals at significant risk for deliberate overdose.

H. TMS and ECT should be considered for treatment of major depressive disorder that does not respond sufficiently to two adequate trials of antidepressant medications, where risk of immediate suicide is high, and where comorbid general medical conditions preclude the safe use of antidepressants. Although esketamine nasal spray (SPRAVATO) is not available in BHS clinics due to monitoring restrictions, it should not be entirely disregarded. If TMS and ECT are considered for reasons listed above and have failed or are contraindicated, esketamine can be considered via an outside referral. Referrals and authorizations of TMS, ECT, esketamine, or any other modalities are processed through Quality Management Services (QMS) Complex Care Coordination (CCC) team. Any of the Associate Medical Directors or Medical Director can help facilitate the referral.

I. For pregnant women who have a major depression, antidepressant prescription should be accompanied by documentation in the medical record of attempted notification of the primary care provider or obstetrician/gynecologist if known and informed consent, including the consideration and discussion of the risks/benefits of using a specific antidepressant. Although there may one day be a role for TMS or ECT during pregnancy, at this time they are basically experimental and will not be considered while in BHS outpatient clinics.

VII. Use of Antidepressants in Bipolar Disorders

A. Essential Use: Antidepressant medication may be given with concurrent mood stabilizing medication for treatment of bipolar disorder, depressive episode.

B. Precaution: Antidepressant medication potentially could induce rapid cycling. Any long-term use of an antidepressant in these individuals should take place with ongoing careful monitoring for mood symptoms and the individuals risk vs benefit of continued use.

VIII. Use of Adjunctive Medications with Antidepressant Medications

A. When psychotic symptoms are present, antipsychotic medications may be used in conjunction with antidepressant medications for treatment of depressive episodes during major depressive disorder, bipolar disorders, substance-induced disorders with mood symptoms, and disorders with mood symptoms due to general medical conditions.

B. Phenothiazine antipsychotic medications should not be used adjunctively with tricyclic medications due to increased risk for untoward cardiovascular effects and lowering of seizure threshold.

C. Mood stabilizing medications should, in general, be used in conjunction with antidepressant medications when treating depressive symptoms in bipolar disorders in order to minimize the likelihood of a manic episode.

D. Antidepressants should be used only during depressive episodes in bipolar I disorder, as longer-term use is associated with increased risk of manic episodes.

E. Selected antipsychotic medications, lithium or triiodothyronine may be used during depressive episodes to augment the therapeutic response to antidepressant medication when antidepressant medications alone are not effective.

F. Dosage schedules should be adjusted based upon age and the presence of general medical conditions.

IX. Antidepressant Medication Dosages

A. Dosage schedules of antidepressant medications should be determined by clinical situation and, with nortriptyline, imipramine, and desipramine, laboratory monitoring of medication blood levels as necessary.

B. Trials of antidepressant medications should be at dosages generally recognized as effective, unless untoward effects prevent this. In such cases, the individual should be switched to a different antidepressant medication.

X. Antidepressants and Suicidal Ideation and Behavior FDA Black Box Warning:

A. The FDA “Black Box Warning” regarding suicidal behavior, as follows and currently attached to all antidepressants, should be carefully reviewed:

"Suicidality in Children and Adolescents
Antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children and adolescents with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of [Drug Name] or any other antidepressant in a child or adolescent must balance this risk with the clinical need. Patients who are started on therapy should be observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. [Drug Name] is not approved for use in pediatric patients except for patients with [Any approved pediatric claims here]. (See Warnings and Precautions: Pediatric Use)Pooled analyses of short-term (4 to 16 weeks) placebo-controlled trials of nine antidepressant drugs (SSRIs and others) in children and adolescents with MDD, obsessive compulsive disorder (OCD), or other psychiatric disorders (a total of 24 trials involving over 4400 patients) have revealed a greater risk of adverse events representing suicidal thinking or behavior (suicidality) during the first few months of treatment in those receiving antidepressants. The average risk of such events on drug was 4%, twice the placebo risk of 2%. No suicides occurred in these trials."

B. Individuals started on antidepressants should be specifically cautioned to immediately report any emergent suicidal ideation or intent to the assigned clinician, psychiatrist, nurse practitioner, or Centralized Assessment Team (CAT) if occurring outside of normal business hours—or 911 if the case is an emergency.

C. Individuals for whom antidepressants are prescribed should be regularly questioned about the presence of dysphoria, restlessness, and emergent suicidal ideation and behavior, and responses should be documented.

D. Individuals with emergent suicidal ideation or behavior who have recently been started on SSRIs should be immediately assessed to determine if a non-SSRI antidepressant medication would be more appropriate.

XI. Laboratory Monitoring for Antidepressant Medications

A. Laboratory monitoring of individuals taking antidepressant medications should be determined by clinical situation, including type of medication, health risk factors, duration of treatment, concurrent general medical condition, and concurrent medications, and should be consistent with the general parameters discussed in General Health-Related Monitoring, Interventions and Consultation.

B. Baseline EKG should be obtained prior to treatment with tricyclic antidepressants in individuals with cardiac disease or who are over age 55.