BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

PHARMACY COVERAGE GUIDELINE

EXXUA™ (gepirone) ER tablet
Generic Equivalent (if available)

This Pharmacy Coverage Guideline (PCG):
- Provides information about the reasons, basis, and information sources we use for coverage decisions
- Is not an opinion that a drug (collectively "Service") is clinically appropriate or inappropriate for a patient
- Is not a substitute for a provider's judgment (Provider and patient are responsible for all decisions about appropriateness of care)
- Is subject to all provisions e.g. (benefit coverage, limits, and exclusions) in the member's benefit plan; and
- Is subject to change as new information becomes available.

Scope
- This PCG applies to Commercial and Marketplace plans
- This PCG does not apply to the Federal Employee Program, Medicare Advantage, Medicaid or members of out-of-state Blue Cross and/or Blue Shield Plans

Instructions & Guidance
- To determine whether a member is eligible for the Service, read the entire PCG.
- This PCG is used for FDA approved indications including, but not limited to, a diagnosis and/or treatment with dosing, frequency, and duration.
- Use of a drug outside the FDA approved guidelines, refer to the appropriate Off-Label Use policy.
- The "Criteria" section outlines the factors and information we use to decide if the Service is medically necessary as defined in the Member's benefit plan.
- The "Description" section describes the Service.
- The "Definition" section defines certain words, terms or items within the policy and may include tables and charts.
- The "Resources" section lists the information and materials we considered in developing this PCG
- **We do not accept patient use of samples as evidence of an initial course of treatment, justification for continuation of therapy, or evidence of adequate trial and failure.**
- Information about medications that require prior authorization is available at www.azblue.com/pharmacy. You must fully complete the request form and provide chart notes, lab workup and any other supporting documentation. The prescribing provider must sign the form. Fax the form to BCBSAZ Pharmacy Management at (602) 864-3126 or email it to Pharmacyprecert@azblue.com.

Criteria:

➢ **Criteria for initial therapy:** Exxua (gepirone) ER tab and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met:

1. Prescriber is a physician specializing in the patient's diagnosis or is in consultation with a Psychiatrist
2. Individual is 18 years of age or older
3. Individual has a confirmed diagnosis major depressive disorder (MDD)
4. Individual has completed **ALL** the following **baseline tests** before initiation of treatment and will have continued monitoring as clinically appropriate:
    a. Potassium and magnesium abnormalities have been corrected

b. Electrocardiogram (ECG)
c. The QTc is less than 450 msec
d. Screen for a personal or family history of bipolar disorder, mania, or hypomania

5. **If available:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

6. Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for **ONE** SSRI **and ONE** SNRI:
   a. SSRI agents include:
      i. Citalopram or escitalopram
      ii. Fluoxetine
      iii. Fluvoxamine
      iv. Paroxetine
      v. Sertraline
   b. SNRI agents include:
      i. Desvenlafaxine
      ii. Duloxetine
      iii. Venlafaxine HCl ER
      iv. Venlafaxine HCl

7. Individual is not taking other drugs that have significant drug interactions

8. There are **NO** FDA-label contraindications such as:
   a. Prolonged QTc interval greater than 450 msec at baseline
   b. Congenital long QT syndrome
   c. Concomitant use of strong CYP3A4 inhibitors
   d. Severe hepatic impairment (Child-Pugh Class C)
   e. Use with an MAOI or within 14 days of stopping treatment with MAOI

9. Individual is not on concurrent strong CYP3A4 inducers

Initial approval duration: 6 months

- **Criteria for continuation of coverage (renewal request):** Exxua (gepirone) ER tab and/or generic equivalent (if available) is considered ***medically necessary*** and will be approved when **ALL** the following criteria are met **(samples are not considered for continuation of therapy)**:

1. Individual continues to be seen by a physician specializing in the patient's diagnosis or is in consultation with a Psychiatrist

2. Individual has documentation of positive clinical response to therapy defined as the following:
   a. Improved mood, behavior, interest in daily activities, sleep, energy, sense of worthiness
   b. No thoughts of suicide and no attempts, no hospitalizations for suicide
   c. No aggression or violent behavior

3. Individual has been adherent with the medication

4. **If available:** Individual has failure after adequate trial, contraindication per FDA label, intolerance, or is not a candidate for a **generic equivalent** [Note: Failure, contraindication or intolerance to the generic should be reported to the FDA] (see Definitions section)

5. Individual has not developed any contraindications or other significant adverse drug effects that may exclude continued use such as:
    a. QT prolongation
    b. Serotonin syndrome
    c. Activation of mania/hypomania
    d. Clinical worsening and emergence of suicidal thoughts and behaviors

6. Individual is not taking other drugs that have significant drug interactions

7. Individual is not on concurrent strong CYP3A4 inducers

Renewal duration: 12 months

- Criteria for a request for non-FDA use or indication, treatment with dosing, frequency, or duration outside the FDA-approved dosing, frequency, and duration, refer to one of the following Pharmacy Coverage Guideline:

1. **Off-Label Use of Non-Cancer Medications**

2. **Off-Label Use of Cancer Medications**

Description:

Exxua (gepirone) ER tab is indicated for the treatment of major depressive disorder (MDD) in adults. The mechanism of the antidepressant effect of Exxua (gepirone)is not fully understood but is thought to be related to its modulation of serotonergic activity in the CNS through selective agonist activity at 5HT1A receptors.

Definitions:

U.S. Food and Drug Administration (FDA) MedWatch Forms for FDA Safety Reporting
MedWatch Forms for FDA Safety Reporting | FDA

Resources:

Exxua (gepirone) ER tab product information, revised by Fabre-Kramer 09-2023. Available at DailyMed http://dailymed.nlm.nih.gov. Accessed October 03, 2025.

Rush AJ. Major depressive disorder in adults: Approach to initial therapy. In: UpToDate, Roy-Byrne PP, McCarron R, Swenson S, Solomon D. (Ed)s, UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through September 2025. Topic last updated February 21, 2025. Accessed October 14, 2025.

Rush AJ. Major depressive disorder in adults: Initial treatment with antidepressants. In: UpToDate, Roy-Byrne PP, McCarron R, Swenson S, Solomon D. (Ed)s, UpToDate, Waltham MA.: UpToDate Inc. Available at http://uptodate.com. Literature current through September 2025. Topic last updated July 23, 2025. Accessed October 14, 2025.