AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Auvelity™ (dextromethorphan HBr and bupropion HCl ER tablets 45 mg/105 mg)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Recommended Dosage: One tablet twice a day separated by at least 8 hours.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member is 18 years of age or older
- ❑ Member has a diagnosis of major depressive disorder (MDD)
- ❑ Member must **NOT** have hypersensitivity to bupropion, dextromethorphan, or any component of the requested medication
- ❑ Provider attests that member has been screened for personal or family history of bipolar disorder, mania, and hypomania
- ❑ Provider attests that member is **NOT** undergoing abrupt discontinuation of alcohol, benzodiazepines, barbiturates, or antiepileptic drugs

(Continued on next page)

- ❑ Member will **NOT** take a monoamine oxidase inhibitor (MAOI) within 14 days of Auvelity™
- ❑ Member does **NOT** have any of the following:
  - A seizure disorder
  - A diagnosis of bulimia or anorexia nervosa
  - A diagnosis of severe hepatic or severe renal impairment
- ❑ Member has had at least a 30-day trial and failure of a serotonin-norepinephrine reuptake inhibitor (SNRI) (e.g., venlafaxine, desvenlafaxine, duloxetine) **(verified by chart notes or pharmacy paid claims)**
- ❑ Member has had at least a 30-day trial and failure of a selective serotonin reuptake inhibitor (SSRI) (e.g., citalopram, sertraline, fluoxetine) **(verified by chart notes or pharmacy paid claims)**
- ❑ Member has had at least a 30-day trial and failure of one other antidepressant agent (e.g., bupropion, mirtazapine, TCA) **(verified by chart notes or pharmacy paid claims)**

Check each drug that has been tried. If not checked, authorization process will be delayed.		
❑ bupropion	❑ citalopram	❑ desvenlafaxine
❑ duloxetine	❑ escitalopram	❑ fluoxetine
❑ mirtazapine	❑ paroxetine	❑ sertraline
❑ venlafaxine ER	❑ Other: _____	

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~10/19/2017; 5/25/2023;~~ **9/26/2024**
REVISED/UPDATED/REFORMATTED: ~~12/27/2017; 1/11/2018; 5/3/2018; 9/26/2018; 9/6/2019; 10/11/2021; 5/11/2023; 6/15/2023; 10/26/2023;~~ **10/15/2024**