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 AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

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

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

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 bupropion **(verified by chart notes or pharmacy paid claims)**
- ❑ Member has had at least a 30-day trial and failure of a serotonin-norepinephrine reuptake inhibitor (SNRI) medication such as venlafaxine, desvenlafaxine or 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) medication such as citalopram, sertraline or fluoxetine **(verified by chart notes or pharmacy paid claims)**

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.*****