Mountain Pacific
INNOVATING BETTER HEALTH

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Montana Healthcare Programs Prior Authorization Request Form for Use of Auvelity® (dextromethorphan/bupropion 45/105 mg extended release)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of major depressive disorder: ☐ Yes ☐ No
3. Member has had a trial (8 weeks duration) and had an inadequate response, intolerance, or contraindication to, two preferred agents with different mechanisms of action in the Novel Antidepressant category on the Montana Healthcare Programs Preferred Drug List:

   Drug name: _____ **Dates of use:** _____

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4. Prescriber attests to the following:

   ☐ Prescriber has discussed with the member the box warning regarding risk of suicidal thoughts and behaviors with this medication.

   ☐ Member **will not** take a Monoamine Oxidase Inhibitor within 14 days of Auvelity®.

   ☐ Member does not have:
   - A seizure disorder **OR**
   - A diagnosis of bulimia or anorexia nervosa **OR**
   - A diagnosis of severe hepatic or severe renal impairment **AND**

   ☐ Member has not abruptly discontinued alcohol, benzodiazepines, barbiturates or antiepileptic medications.

   ☐ Member's risk for abuse or misuse is assessed prior to initiating treatment and will be assessed periodically while on therapy. (Auvelity® is not a scheduled medication and did not indicate drug seeking behavior in clinical studies. However, the active drugs in Auvelity® independently have reports of misuse.)

LIMITATIONS:

Maximum dose allowed: 2 tablets per day

Initial authorization will be granted for 6 weeks.

☐ CONTINUATION OF THERAPY

1. Member has documentation (please attach) of positive clinical response to therapy as demonstrated by a reduction in symptom severity compared to the baseline depression assessment utilizing the same rating scale:
   ☐ Yes ☐ No

LIMITATIONS:

Maximum dose allowed: 2 tablets per day

Reauthorization will be issued for 1 year.

Please complete form, including required attachments, and fax to the Drug Prior Authorization Unit at 1-800-294-1350.

11/2022