Prescriber Criteria Form

Auvelity 2025 PA Fax 5576-A v1 010125.docx
Auvelity (dextromethorphan hydrobromide/bupropion hydrochloride)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Auvelity (dextromethorphan hydrobromide/bupropion hydrochloride).

Drug Name:
Auvelity (dextromethorphan hydrobromide/bupropion hydrochloride)

| | | |
|---|---|---|
| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
|---|---|---|---|
| 1 | Is the requested drug being prescribed for the treatment of major depressive disorder (MDD)?<br>[If no, then no further questions.] | Yes ◯ | No ◯ |
| 2 | Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to two of the following: A) serotonin and norepinephrine reuptake inhibitors (SNRIs), B) selective serotonin reuptake inhibitors (SSRIs), C) mirtazapine, D) bupropion? | Yes ◯ | No ◯ |

Comments: _____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

**Prescriber (or Authorized) Signature:** _____ **Date:**_____