US Family Health Plan
Prior Authorization Request Form for
dextromethorphan hydrobromide and bupropion hydrochloride **(Auvelity).**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Medical documentation may be required. Failure to provide could result in denial.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a history of seizure disorder or conditions that increase the risk of seizure (for example; bulimia, anorexia nervosa, severe head injury)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Does the provider acknowledge that they discussed with the patient that non-pharmacologic interventions (for example: CBT, sleep hygiene) are encouraged to be used in conjunction with this medication?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient being treated for depression?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed generic extended release bupropion HCL at maximally tolerated dose?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a contraindication to, intolerability to, or have they failed a trial of TWO other formulary antidepressant medications [for example: for selective serotonin reuptake inhibitor (SSRI) (citalopram, escitalopram, fluoxetine), for serotonin-norepinephrine reuptake inhibitor (SNRI) (venlafaxine IR, venlafaxine ER, desvenlafaxine succinate ER)] (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

[17 May 2023]

_____ _____
Prescriber Signature Date