# Auvelity (bupropion/dextromethorphan)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| **MEMBER INFORMATION** | | |
|---|---|---|
| **LAST NAME:** | **FIRST NAME:** | |
| **PHONE NUMBER:** | **DATE OF BIRTH:** | |
| **STREET ADDRESS:** | | |
| **CITY:** | **STATE:** | **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | | |
|---|---|---|
| **LAST NAME:** | **FIRST NAME:** | |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** | |
| **NPI NUMBER:** | **DEA NUMBER:** | |
| **PHONE NUMBER:** | **FAX NUMBER:** | |
| **STREET ADDRESS:** | | |
| **CITY:** | **STATE:** | **ZIP CODE:** |
| **REQUESTER (if different than prescriber):** | **OFFICE CONTACT PERSON:** | |

| **MEDICATION OR MEDICAL DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** **IF RENEWAL:** DATE THERAPY INITIATED: DURATION OF THERAPY (SPECIFIC DATES): | | | |

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| **1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ **YES** (if yes, complete below) ☐ **NO** | | |
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE)**:** | **DURATION OF THERAPY** (SPECIFY DATES)**:** | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ Major Depressive Disorder<br>☐ Agitation associated with dementia due to Alzheimer's disease<br>☐ Other diagnosis: _____ ICD-10 Code(s): | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Is patient going to be using drug in combination with a clinical trial?** ☐ **Yes** ☐ **No**

**Does patient have diagnosis of major depressive disorder (MDD)?** □ **Yes** □ **No**

**Has patient tried and failed bupropion?** □ **Yes** □ **No Please provide dates of service.**

**Has patient tried and failed at least 3 other antidepressants?** □ **Yes** □ **No Please provide dates of service.**

**Does patient have probable Alzheimer's disease(AD) according to 2011 NIA-AA criteria?** □ **Yes** □ **No Please provide documentation.**

**Is Auvelity(bupropion/dextromethorphan) to be used in a patient who has agitation associated with Alzheimer's Disease?** □ **Yes** □ **No Please provide documentation.**

**Is the agitation attributable another psychiatric disorder, suboptimal care conditions, medical condition, or the physiological effects of a substance?** □ **Yes** □ **No Please provide documentation.**

**Does the patient have a Mini-Mental Status Exam(MMSE) score 10-24 (inclusive)?** □ **Yes** □ **No Please provide documentation.**

**Does patient have a Neuropsychiatric Inventory Agitation/Aggression(NPI-AA) score ≥4?** □ **Yes** □ **No Please provide documentation.**

**Has patient had symptoms of agitation for at least 1 week prior to starting Auvelity(bupropion/dextromethorphan)?** □ **Yes** □ **No Please provide documentation.**

**Does patient have a history of bipolar disorder or a psychotic disorder not related to dementia?** □ **Yes** □ **No Please provide documentation.**

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**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

_____

_____

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____

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**FAX THIS FORM TO:** 800-424-7640
**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
**Phone**: 877-228-7909

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