TRICARE Prior Authorization Request Form for
dextromethorphan hydrobromide and bupropion hydrochloride **(Auvelity).**

JOHNS HOPKINS MEDICINE

JOHNS HOPKINS HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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:**

Question	Yes	No
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:

______________________ Prescriber Signature ______________ Date

[17 May 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: