Reference number(s)
5562-E

Initial Step Therapy with Quantity Limit; Post Step Therapy Prior Authorization with Quantity Limit
Auvelity

Products Referenced by this Document

Drugs that are listed in the following table include both brand and generic and all dosage forms and strengths unless otherwise stated. Over-the-counter (OTC) products are not included unless otherwise stated.

Brand Name	Generic Name
Auvelity	dextromethorphan/bupropion hydrochloride

Indications

FDA-approved Indications

Auvelity is indicated for the treatment of major depressive disorder (MDD) in adults.

Screen Out Logic with Quantity Limit

Include Rx and OTC products unless otherwise stated.

If the patient has filled a prescription for at least a 30 day supply of a serotonin and norepinephrine reuptake inhibitor (SNRI), a selective serotonin reuptake inhibitor (SSRI), mirtazapine OR bupropion (except generic for Zyban) within the past 180 days under a prescription benefit administered by CVS Caremark, then the requested drug will be paid under that prescription benefit. If the patient does not meet the screen out logic criteria, then the claim will reject with a message indicating that a prior

authorization (PA) is required. The prior authorization criteria would then be applied to requests submitted for evaluation to the PA unit.

If the patient meets the screen out logic criteria, then the initial limit criteria will apply. If the patient is requesting more than the initial quantity limit the claim will reject with a message indicating that a PA is required.

Initial Limit Quantity

The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.

Drug	1 Month Limit	3 Month Limit
Auvelity (dextromethorphan/bupropion hydrochloride)	60 tablets / 25 days	180 tablets / 75 days

Coverage Criteria

Major Depressive Disorder (MDD)

Authorization may be granted when the requested drug is being prescribed for the treatment of major depressive disorder (MDD) in an adult patient

Quantity Limits Apply

60 tablets per 25 days or 180 tablets per 75 days

The duration of 25 days is used for a 30-day fill period and 75 days is used for a 90-day fill period to allow time for refill processing.

Duration of Approval (DOA)

- 5562-E: DOA: 12 months

References

1. Auvelity [package insert]. New York, NY: Axsome Therapeutics, Inc.; December 2022.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. https://online.lexi.com. Accessed May 14, 2024.
3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 05/10/2024).
4. American Psychiatric Association (2010). Practice Guideline for the Treatment of Patients with Major Depressive Disorder. Available from: https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf. Accessed May 14, 2024.