Disclaimer: Use of this template or the information in this template does not guarantee
reimbursement for coverage. It is not intended to be a substitute for or to influence the
independent clinical decision of the prescribing healthcare professional. The completion
and accuracy of this form is the sole responsibility of the healthcare provider.

**Cover Page for Letter of Medical Necessity for Auvelity**™ **(dextromethorphan-bupropion)**

**The following pages are a template that may be customized to use as a letter of
medical necessity to be submitted with a Prior Authorization request for Auvelity.**

<Date>

**ATTENTION:** <Medical Director Name and/or Medical Review/Appeals>

<Payer/Health Plan Name>

<Payer Address>

**REGARDING:** Request for Medical Necessity for Auvelity (dextromethorphan-bupropion)
extended-release tablets

**PATIENT NAME:** <Patient Name>

**DATE OF BIRTH:** <Patient Date of Birth>

**POLICY ID NUMBER:** <Patient Policy ID Number>

**PROVIDER ID NUMBER:** <Provider ID Number>

<Optional: Claim rejection number>

Dear <Health Plan Contact Name>:

I am writing this letter of medical necessity in support of my request to treat <Patient Name> with Auvelity for the treatment of major depressive disorder (MDD) in adults.

As a <board-certified> <Field of Certification> with <##> years caring for patients with MDD, I believe that treatment with Auvelity is warranted, appropriate, and medically necessary for this patient based on my clinical judgment and expertise.

The following is the medical history of <Patient Name> and the rationale for treatment with Auvelity. I have also attached to this letter the clinical findings that summarize my patient’s current medical condition and the Auvelity package insert/prescribing information.

|  |  |
| --- | --- |
| **Date of Diagnosis** | <MM/DD/YY> |
| **Diagnosis** | <ICD-10 code> |
| **Summary of clinical symptoms** | * <Patient’s current condition, including an overview of symptoms and quality of life or functional impairment as applicable>
* <Evaluation test score(s)>
* <Prognosis without treatment>
 |
| **Previous and current treatment regimens** | <If applicable, include previous and current pharmacologic treatments for MDD, including drug name, dates of use, and reasons for stopping> |

I would like to prescribe Auvelity for <Patient Name> because I have concluded that it is a medically appropriate and necessary therapeutic option for the following reason(s):

<Rationale for treating the patient with Auvelity. In this rationale, include a description of the patient’s disease state, treatment history, comorbid health issues, and any other factors that have influenced your treatment decision.>

<You may wish to include relevant background or clinical trial information about Auvelity in the letter. For additional information, please refer to the Auvelity Prescribing Information.>

Given the patient’s history, <his/her/their> current condition, and the data of the effects of Auvelity in patients with MDD, I believe that treatment of <Patient Name> with this product is warranted, appropriate, and medically necessary. The totality of the data available to date supports the potential benefit of <treatment/continuing treatment> with Auvelity.

Please call my office at <telephone number> if I can provide you with any additional information. I look forward to receiving your timely response.

Best regards,

<Physician Signature>

<Physician Name>
<Physician Contact Information>

**ATTACHMENTS:**

* Auvelity package insert/prescribing information
* Patient clinical notes and other relevant supporting documentation

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