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| Clinical Policy Title: | Bupropion and dextromethorphan |
| Policy Number: | RxA.775 |
| Drug(s) Applied: | Auvelity |
| Original Policy Date: | 9/12/2024 |
| Last Review Date: | 12/11/2025 |
| Line of Business Policy Applies to: | All lines of business (except Medicare) |

Criteria

I. Initial Approval Criteria

A. Major depressive disorder (must meet all):

1. Diagnosis of major depressive disorder;
2. Trial and failure of at least two (2) different antidepressants from two (2) different mechanisms of action used for at least 30 days each within the past 12 months, unless contraindicated or adverse effects are experienced:
 - a. Selective serotonin reuptake inhibitors (e.g., sertraline, citalopram);
 - b. Serotonin and norepinephrine reuptake inhibitors (e.g., duloxetine, venlafaxine);
 - c. Tricyclic antidepressants (e.g., amitriptyline, doxepin);
 - d. Monoamine oxidase inhibitors (e.g., phenelzine, tranylcypromine);
 - e. Bupropion;
 - f. Mirtazapine;
 - g. Trazodone;

Approval Duration

All lines of business (except Medicare): 12 months

II. Continued Therapy Approval

A. Major depressive disorder (must meet all):

1. Member is currently receiving medication that has been authorized by RxAdvance or the member has met initial approval criteria.

Approval Duration

All Lines of Business (except Medicare): 12 months

References

McCarthy B, Bunn H, Santalucia M, Wilmoth C, Muzyk A, Smith CM. Dextromethorphan-bupropion (Auvelity) for the Treatment of Major Depressive Disorder. Clin Psychopharmacol Neurosci. Available at: <https://pmc.ncbi.nlm.nih.gov/articles/PMC10591164/>. Accessed December 5, 2024.

| Review/Revision History | Review/Revision Date | P&T Approval Date |
|-------------------------|----------------------|-------------------|
| Policy established. | 11/07/2024 | 12/05/2024 |
| Policy updated: | 2/14/2025 | |

This clinical policy has been developed to authorize, modify, or determine coverage for individuals with similar conditions. Specific care and treatment may vary depending on individual need and benefits covered by the plan. This policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. This document may contain prescription brand name drugs that are trademarks of pharmaceutical manufacturers that are not affiliated with RxAdvance.

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| <ol style="list-style-type: none"> 1. Removed criteria: Prescribed in combination with an oral antidepressant 2. Changed t/f language for clarity: Trial and failure of at least two (2) different antidepressants from two (2) different mechanisms of action used for at least 30 days each within the past 12 months, unless contraindicated or adverse effects are experienced: | | |
| Policy reviewed. | 12/11/2025 | 12/11/2025 |