



Please complete ALL information below and fax your request to 1-888-671-5285

Aplenzin[®] and Forfivo XL[®] (bupropion extended-release (ER) 450mg) Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)			Strength:	Dosage Form:	
<input type="checkbox"/> Check if request is for continuation of therapy			Directions for Use:		
Clinical Information (required)					
Select the Type(s) of Coverage Determination Requested:					
<input type="checkbox"/> Step Therapy - Request is for an exception to try another drug before the requested drug being prescribed.					
Select the diagnosis below:					
<input type="checkbox"/> Major depressive disorder (MDD)					
<input type="checkbox"/> Seasonal affective disorder (SAD)					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Select the medication(s) the patient has a history of trial and failure, or intolerance to:					
<input type="checkbox"/> Bupropion					
<input type="checkbox"/> Bupropion extended-release (XL)					
<input type="checkbox"/> Bupropion sustained-release (SR)					

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: This request may be denied unless all required information is received.

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