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: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Step Therapy**- Request is for an exception to try another drug before the requested drug being prescribed.

Select the diagnosis below:

❑ Major depressive disorder (MDD)
❑ Seasonal affective disorder (SAD)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medication(s) the patient has a history of trial and failure, or intolerance to:

❑ Bupropion
❑ Bupropion extended-release (XL)
❑ 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.