



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: [www.express-scripts.com/pa](http://www.express-scripts.com/pa)

Fax completed form to **1-800-357-9577**

If this an **URGENT** request, please call at 1-800-417-8164

**Patient Information**

Patient First Name: \_\_\_\_\_

Patient Last Name: \_\_\_\_\_

Patient ID#: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

**Prescriber Information**

Prescriber Name: \_\_\_\_\_

Prescriber DEA/NPI (required): \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_

Prescriber Fax #: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Please indicate which drug and strength is being requested:

- Aplenzin 174mg
- Aplenzin 348mg
- Aplenzin 522mg
- Wellbutrin SR 100mg
- Wellbutrin SR 150mg
- Wellbutrin SR 200mg
- Wellbutrin XL 150mg
- Wellbutrin XL 300mg
- Other: \_\_\_\_\_

Directions for use (i.e. QD, BID, PRN & Qty): \_\_\_\_\_

**Please complete the clinical assessment:**

1. Is the patient currently taking the requested medication? If yes, how long has the patient been taking the medication? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: <input type="checkbox"/> Requested medication covered under previous insurance plan <input type="checkbox"/> Started medication in hospital <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Has the patient tried a generic bupropion sustained-release or generic extended-release tablet? If yes, please indicate: <input type="checkbox"/> Budeprion XL <input type="checkbox"/> Budeprion SR <input type="checkbox"/> Bupropion extended-release tablets <input type="checkbox"/> Bupropion sustained-release tablets <input type="checkbox"/> Other: _____ _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?**

---

---

---

---

---

---

---

---

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.