



DATE _____

CLIENT _____

PRIOR AUTHORIZATION QUESTIONNAIRE-Aplenzin™ (bupropion HBr)

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

****FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL****

PA CRITERIA FOR APPROVAL

1. Diagnosis:

- Major Depressive Disorder
- Other (please specify) _____

2. Indicate **all** that apply:

- Patient with seizure disorder
- Patient using other bupropion products, including Zyban®
- Current or prior diagnosis of bulimia or anorexia nervosa
- Abrupt discontinuation of alcohol, sedatives (including benzodiazepines)
- Current use within last 2 weeks of a MAO inhibitor (Ex. Emsam, Marplan, Nardil, Parnate (tranylcypromine))
- Patient allergic to any of the ingredients of Aplenzin™

3. Is the patient currently stable on the medication? Yes No

a. If Yes, provide the date therapy was initiated _____

b. If No, proceed to Question #4

4. Has the patient tried and failed Wellbutrin®, Wellbutrin SR®, or Wellbutrin XL®? Yes No

a. If Yes, provide dates of trial _____

b. If No, provide the rationale for non-trial. Please further clarify if requesting 174 mg or 348 mg, please also provide the rationale for requesting this drug over that of generic Wellbutrin XL® 150 mg or 300 mg.

5. Dose Requested: 174 mg 348 mg 522 mg

6. Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906

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