

Prior Authorization Form
Date Criteria: 04/01/2009
CAREFIRST BLUECROSS BLUESHIELD

Aplenzin

Complete information, sign and date. Fax completed forms to Argus at 1-800-315-4025.
This fax machine is located in a secure location as required by HIPAA regulations.

When conditions are met, we will authorize coverage of Aplenzin.
Please contact Argus at 1-800-314-2872 with questions regarding the prior authorization process.

Drug Name: _____

Patient:

Patient Name: _____
Patient ID: _____
Patient's Group Number: _____
Patient's Date of Birth: _____

Prescribing Physician:

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Prescriber ID: _____
Physician Address: _____
Physician City, State, Zip: _____

1. Does the patient have a diagnosis of Major Depressive Disorder (MDD). If yes, please answer question 2.

Y **N**

2. Has the patient tried for at least two months and failed therapy with either Wellbutrin, Wellbutrin XL, Wellbutrin SR or generic bupropion for this condition?
If yes, please provide the names of the drugs, including strength and dosage and dates used.

Y **N**

Information given on this form is accurate as of this date.

Prescriber or Authorized Signature

Date