

**Zurzuvae™ (zuranolone) Prior Authorization Form****Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Member ID#:** \_\_\_\_\_**Drug Information****Pharmacy Billing (NDC:** \_\_\_\_\_ **) Start Date (or date of next dose):** \_\_\_\_\_**Dose:** \_\_\_\_\_ **Regimen:** \_\_\_\_\_**Pharmacy Information****Pharmacy NPI:** \_\_\_\_\_ **Pharmacy Name:** \_\_\_\_\_**Pharmacy Phone:** \_\_\_\_\_ **Pharmacy Fax:** \_\_\_\_\_**Prescriber Information****Prescriber NPI:** \_\_\_\_\_ **Prescriber Name:** \_\_\_\_\_**Prescriber Phone:** \_\_\_\_\_ **Prescriber Fax:** \_\_\_\_\_ **Specialty:** \_\_\_\_\_**Criteria****For Authorization:** (Approvals will be for 1 treatment course)

1. Please indicate the diagnosis and information:

 **Moderate to Severe Postpartum Depression (PPD)** **Other** \_\_\_\_\_

2. Please provide the date of delivery: \_\_\_\_\_

3. Is the member currently pregnant? Yes \_\_\_ No \_\_\_

4. Does the member agree to use effective contraception while receiving treatment and for 7 days after the last dose of Zurzuvae™? Yes \_\_\_ No \_\_\_

5. Has member been counseled on the proper administration of Zurzuvae™ including taking with a fat-containing meal? Yes \_\_\_ No \_\_\_

6. Has member been counseled on the central nervous system (CNS) depression effects of Zurzuvae™ and agrees not to drive or engage in other potentially hazardous activities until at least 12 hours after administration? Yes \_\_\_ No \_\_\_

7. Does member have severe hepatic impairment or moderate to severe renal impairment? Yes \_\_\_ No \_\_\_

8. Will Zurzuvae™ be used concomitantly with CYP3A4 inhibitors? Yes \_\_\_ No \_\_\_

9. If a dose reduction to 40mg once daily is required due to CNS depression effects, the prescriber should contact the specialty pharmacy that filled the member's initial Zurzuvae™ prescription to obtain the 20mg capsules from the manufacturer for the remainder of the member's treatment course.

**Additional Information:** \_\_\_\_\_**Prescriber Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

**PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:**University of Oklahoma College of Pharmacy  
Pharmacy Management Consultants  
Product Based Prior Authorization UnitFax: 1-800-224-4014  
Phone: 1-800-522-0114 Option 4**CONFIDENTIALITY NOTICE**

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