South Dakota Department of Social Services

Please note: All information below is required to process this request.
**Fax to 1-844-403-1029**
**Mon-Sat: 7am to 7pm Central**

# Zurzuvae™ Prior Authorization Request Form

**DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED**

## Member Information (required)

| | | |
|---|---|---|
| Member Name: | | |
| Insurance ID#: | | |
| Date of Birth: | | |
| Street Address: | | |
| City: | State: | Zip: |
| Phone: | | |

## Provider Information (required)

| | | |
|---|---|---|
| Provider Name: | | |
| NPI#: | Specialty: | |
| Office Phone: | | |
| Office Fax: | | |
| Office Street Address: | | |
| City: | State: | Zip: |

## Medication Information (required)

| | | |
|---|---|---|
| Medication Name: | Strength: | Dosage Form: |
| ❑ Check if requesting **brand** | Directions for Use: | |
| ❑ Check if request is for **continuation of therapy** | | |

## Clinical Information (required)

**Select the diagnosis and list the rating scale and score below:**

❑ Diagnosis of severe postpartum depression as indicated by DSM-5 criteria and/or an appropriate depression rating scale (e.g., HAM-D, MADRS, PHQ-9, etc.) _____

❑ Diagnosis of mild to moderate postpartum depression as indicated by DSM-5 criteria and/or an appropriate depression rating scale (e.g., HAM-D, MADRS, PHQ-9, etc) _____

- ❑ Trial and failure, contraindication or intolerance to at least one oral SSRI or SNRI (e.g., escitalopram, duloxetine, etc)
  List SSRI or SNRI tried and duration _____
- ❑ If disqualifying agents due to contraindications alone (without history of previous failed therapy), contraindications to both SSRI and SNRI classes is required. Documentation must be submitted indicating reasoning behind each contraindication.
  List the contraindications for SSRI and SNRI _____

❑ Other diagnosis: _____ ICD-10 Code(s): _____-_____

**Clinical information:**

When was the onset of symptoms? Provide date: _____

When was the delivery date? Provide date: _____

Has the patient been treated with brexanolone (IV formulation)? ❑ **Yes** ❑ **No** If yes, date: _____

**Prescriber attests that the patient has been counseled and has agreed to adhere to the following:**

- ❑ Patient will follow instructions to not drive or operate machinery until at least 12 hours after taking each dose of Zurzuvae for the duration of the 14-day treatment course and that patients are informed that they may not be able to assess their own driving competence, or the degree of driving impairment caused by Zurzuvae
- ❑ Patient has ceased lactating or breastmilk produced will not be used for feedings during treatment and up to 7 days following last dose
- ❑ Females of reproductive potential should be advised to use effective contraception during treatment and for 1 week after the final dose
- ❑ Therapy will not be used in the same pregnancy as brexanolone (Zulresso)

**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.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.