





Fax Completed Form To 1.833.404.2392

Prescriber Help Desk 1.833.587.2012 Online

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prior-authorization-forms/

Request for Prior Authorization Zuranolone (Zurzuvae)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
	1	
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all inform	nation above. It must be legible, correct, and co	omplete or form will be returned.
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for zuranolone (Zurzuvae). Payment will be considered under the following conditions:

- 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
- 2. Patient has a diagnosis of postpartum depression (PPD); and
- 3. Patient is 12 months or less postpartum on the date of the request (provide date of delivery); and
- 4. The onset of the current depressive episode was during the third trimester or within 4 weeks postpartum; and
- 5. Patient has not received brexanolone for the current PPD episode; and
- 6. Only one course of treatment (i.e., 14 days) per pregnancy will be considered. Extension of therapy beyond 14 days will not be authorized.

Non-Preferred

Zurzuvae

Strength	Usage Instructions	Quantity	Day's Supply	
Diagnosis:				
ls patient 12 months or less	s postpartum on date of request?			
Yes; date of delivery:] No		
Was the onset of the current Yes; Date of onset:	nt depressive episode during the	third trimester or withir	n 4 weeks postpartum?	
Has patient received brexa	nolone for the current PPD episod	de? 🗌 Yes 🗌 No		
Has patient received previc	ous treatment with zuranolone du	ring the current PPD ep	isode? 🗌 Yes 🗌 No	
Attach lab results and othe	er documentation as necessary.			
Prescriber signature (Must m	atch prescriber listed above.)	Date o	f submission	
IMPOPTANT NOTE: In evaluati	ng requests for prior authorization the co	nsultant will consider the tre	atment from the standpoint of	medical

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.