OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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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. Is the member currently breastfeeding? Yes☐ No☐
   a. If yes, will the member temporarily hold breastfeeding while receiving treatment, and for 7 days after the last dose of Zurzuvae™? Yes☐ No☐
      i. If the member does not agree to cease breastfeeding, provider attests the benefits of Zurzuvae™ therapy while breastfeeding outweigh the risks to the infant due to studies showing that Zurzuvae™ is present in the breastmilk? Yes☐ No☐
      ii. Has the member been counseled on the potential risks of CNS depression effects that may occur to the infant? Yes☐ No☐
6. Has member been counseled on the proper administration of Zurzuvae™ including taking with a fat-containing meal? Yes☐ No☐
7. 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☐
8. Does member have severe hepatic impairment or moderate to severe renal impairment? Yes☐ No☐
9. Will Zurzuvae™ be used concomitantly with CYP3A4 inhibitors? Yes☐ No☐

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.
All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

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***Member Name:*_____ *Date of Birth:*_____ *Member ID#:*_____**

Criteria

For Authorization *(continued):*

10. Dosing and approval duration will be limited to the following:
    a. 50mg once daily for 14 days; or
    b. For members with severe hepatic impairment, moderate to severe renal impairment, or concomitant use with CYP3A4 inhibitors:
        i. 30mg once daily for 14 days; and
    c. 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; and
    d. Approvals will be for 1 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.

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