UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Zulresso (brexanolone) and Zurzuvae (zuranolone)

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/Strength:	❑ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*NPI:
*Address:	
*Contact Person:	*Phone #:
*Fax #:	Email:
Medically Billed Information * indicates required field for all medically billed products	
*Diagnosis Code:	*HCPCS Code:
*Dosing Frequency:	*HCPCS Units per dose:
Servicing Provider Name:	NPI:
Servicing Provider Address:	
Facility/Clinic Name:	NPI:
Facility/Clinic Address:	
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Criteria for Approval (All criteria must be met)

- ❑ The patient is 15 years of age or older for Zulresso or 18 years of age or older for Zurzuvae
- ❑ The patient has a diagnosis of moderate to severe postpartum depression shown with a validated depression assessment scale score **AND** requires immediate use of medication (scale name, score): _____
- ❑ The patient is **NOT** currently pregnant
- ❑ The patient is less than 12 months postpartum. Delivery date: _____
- ❑ The provider has documented depression treatment plan, including psychotherapy, following treatment

Note:

- ❖ **Boxed warning for Zurzuvae:** The patient is advised not to drive or engage in other potentially hazardous activities until at least 12 hours after zuranoloneZurzuvae administration for the duration of the 14-day treatment course.
- ❖ Use appropriate HCPCS code for billing Coverage and Reimbursement code look up: https://health.utah.gov/stplan/lookup/CoverageLookup.php HCPCS NDC Crosswalk: https://health.utah.gov/stplan/lookup/FeeScheduleDownload.php

Authorization: One (1) infusion per delivery for Zulresso, up to 14 days per delivery for Zurzuvae

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date