REALRx

# PRIOR AUTHORIZATION REQUEST FORM

## Zurzuvae™

**For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.**

**Failure to submit clinical documentation to support this request will result in a dismissal of the request.**

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

| | | |
|---|---|---|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |
| Height/Weight: | | |

***Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.***

**Product being requested:** ☐ Zurzuvae™ (zuranolone)

Dosing/Frequency:_____

**If the request is for reauthorization, proceed to reauthorization section.**

| Questions | Yes | No | Comments/Notes |
|---|---|---|---|
| 1. Is the request made by, or in consultation with, an OB/GYN or Psychiatric provider? | ☐ | ☐ | **Please provide documentation** |
| 2. Does clinical documentation show the member does NOT have a history of pre-partum major depressive disorder previously treated within the last 12 months prior to the pregnancy? | | | |
| 3. Does the member have a documented diagnosis of a major depressive episode that began no earlier than the third trimester and no later than the first 4 weeks following delivery, as diagnosed by a structured clinical interview for DSM-5? | ☐ | ☐ | **Please provide documentation** |
| 4. Does clinical documentation include one of the following?<br>• Hamilton Depression Rating Scale (HAM-D) score is ≥ 24 (severe depression) OR;<br>• Montgomery and Asberg Depression Rating Scale (MADRS) score is ≥ 35 (severe depression) OR;<br>• Patient Health Questionnaire-9 (PHQ-9) score is ≥ 20 (severe depression) plus Edinburgh Postnatal Depression Scale (EPDS) ≥18 Score OR;<br>• Beck Depression Inventory (BDI) ≥29 (severe depression) OR;<br>• Quick Inventory of Depressive Symptomatology (self-reported) (QIDS-SR) ≥16 OR; | ☐ | ☐ | **Please provide documentation** |

| | | | |
|---|---|---|---|
| • If member does not have severe depression as demonstrated by at least one of the depression scores above), member must have documentation of severe depression as evidenced by an OBGYN or psychiatry clinical interview? | | | |
| 5. Does clinical documentation show no more than 12 months have passed since member has given birth? | ☐ | ☐ | **Please provide documentation** |
| **What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.** | | | |
| Additional information: | | | |
| Physician Signature: | | | |

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Policy: PHARM-158
Origination Date: 12/20/2023
Reviewed/Revised Date: 01/17/2024
Next Review Date: 01/17/2025
Current Effective Date: 02/01/2024