SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Zurzuvae™ (zuranolone)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Optima #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Weight: _____ **Date:** _____

Quantity Limit:

- **20 & 25 mg capsules: 28 capsules per 14-day treatment course**
- **30 mg capsules: 14 capsules per 14-day treatment course**

Provider please note: Zurzuvae™ will **NOT** be approved for the indication of Major Depressive Disorder (MDD) or other psychiatric disorders other than Postpartum Depression. Maximum treatment duration is 14 days.

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: One-time fill

- ❑ Member must be at least 18 years of age
- ❑ Medication is being prescribed by or in consultation with a psychiatrist or an obstetrician-gynecologist

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- ❑ Member has a diagnosis of **severe** Postpartum Depression (PPD) as demonstrated by an objective measurement scale of depressive symptoms (e.g., HAMD-17, MADRS) **(scale and date completed must be attached)**
- ❑ Onset of depressive symptoms occurred during the third trimester **OR** within the first four weeks after delivery
- ❑ Member is 12 months or less postpartum

  Date of Delivery MUST be provided: _____
- ❑ Member must meet **ONE** of the following:
  - ❑ Member is **NOT** currently breastfeeding
  - ❑ Member has agreed to temporarily hold breastfeeding while taking prescribed course of therapy and for one week following completion of therapy
- ❑ Member is **NOT** currently pregnant
- ❑ Member must have experienced clinical failure with at least **ONE** oral antidepressant therapy **(verified by chart notes and pharmacy paid claims)**. Failure must meet the following criteria:
  - ❑ Adequate dose (maximally tolerated)
  - ❑ Adequate duration (at least 6 weeks)
  - ❑ Adherent fills required (verified by pharmacy claims)
  - ❑ Failure must occur during current depressive episode

Medication being provided by Specialty Pharmacy – Proprium Rx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee**: **1/18/2024**
REVISED/UPDATED/REFORMATTED: 2/29/2024