US Family Health Plan
Prior Authorization Request Form for
Zuranolone (Zurzuvae)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization expires after 9 months. Provider must fill out a new PA.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have postpartum depression (PPD)? **Note: Use for major depressive disorder is not allowed.**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient 12 months or less postpartum?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**

4. Does the patient have a contraindication to, intolerability to, or has failed a trial of ONE formulary antidepressant medication (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose)? **Examples of formulary antidepressants include:** • selective serotonin reuptake inhibitors (SSRIs, for example, citalopram, escitalopram, fluoxetine, paroxetine, sertraline), • serotonin/norepinephrine reuptake inhibitors (SNRIs, for example, venlafaxine, duloxetine; not including milnacipran), • tricyclic antidepressants (TCAs, for example, amitriptyline, desipramine, imipramine, nortriptyline), • mirtazapine, • bupropion, • trazodone immediate-release, • nefazodone, and • monoamine oxidase inhibitors (MAOIs)	☐ Yes Proceed to question **8**	☐ No Proceed to question **5**
5. Is the patient currently stable on an antidepressant medication and is experiencing break through symptoms?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Is the patient classified as having severe postpartum depression and/or is at significant risk for harm to self or others as determined by their provider and requires prompt symptom control?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**
7. Is the patient continuing therapy that was initiated during an inpatient hospital stay?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient had previous treatment course with zuranolone during the current postpartum period?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Will the patient use effective contraception during treatment and for one week after the final dose?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Does the provider acknowledge the risk of fetal harm associated with zuranolone exposure in pregnancy and has counseled the patient to avoid conception for the duration of use and one week after final dose?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____