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New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form

Zurzuvae™ (zuranolone)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY:

1. Is the prescriber a psychiatrist or obstetrician/gynecologist or has one been consulted? ☐ Yes ☐ No
2. Does the patient have a diagnosis of severe postpartum depression determined by a standardized screening tool? ☐ Yes ☐ No
3. Date of the onset of symptoms of postpartum depression: _____
4. Date of delivery: _____
5. Has the patient received counseling concerning the potential risk of fetal harm? ☐ Yes ☐ No
6. Has the patient ceased lactating or will the patient refrain from providing breast milk to the infant from the first dose until 7 days after the last dose? ☐ Yes ☐ No

(Form continued on next page.)

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PATIENT LAST NAME: | | | | | | | | | | | | |

PATIENT FIRST NAME: | | | | | | | | | | | | |

SECTION III: CLINICAL HISTORY *(Continued)*

7. Has the patient been counseled to avoid potentially hazardous activities requiring mental alertness for at least 12 hours after each dose? ☐ Yes ☐ No
8. Has the patient been counseled to take the medication with 400–1,000 calories of food containing 25–50% fat? ☐ Yes ☐ No
9. Is the patient taking another oral antidepressant and has been on a stable dose for 30 or more days? ☐ Yes ☐ No
10. Have drug interactions been considered with dosage adjustments when needed? ☐ Yes ☐ No
11. Does the patient have any baseline renal or hepatic dysfunction? ☐ Yes ☐ No
    If yes, indicate the dose adjustment: _____
12. Does the patient have eGFR less than 15 mL/min/1.73 m^2 or require dialysis? ☐ Yes ☐ No
13. Provide any additional information that would help in the decision-making process.
    If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: _____ **DATE**: _____

Phone: 1-800-424-7901
Fax: 1-800-424-7984

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