PA Request Criteria

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207375

CAREFIRST COMMERCIAL - NON-RISK - FORMULARY 1 - SPC
Zurzuvae SGM

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS Caremark at 866-249-6155. Please contact CVS Caremark at 866-814-5506 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Zurzuvae SGM.

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_

Drug Name (select from list of drugs shown)
Zurzuvae
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Post-partum depression (PPD) (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
   _____
2. Does the patient have moderate to severe post-partum depression? **Y** ☐ **N** ☐
3. Has the patient had a major depressive episode, documented by standardized rating scales that reliably measure depressive symptoms (e.g., Beck Depression Inventory [BDI], Hamilton Depression Rating Scale [HDRS], Montgomery-Asberg Depression Rating Scale [MADRS], etc.)? **Y** ☐ **N** ☐
4. Did the major depressive episode occur no earlier than the third trimester of pregnancy and no later than the first 4 weeks following delivery? **Y** ☐ **N** ☐
5. Is the patient currently 12 months postpartum or less? **Y** ☐ **N** ☐
6. Has the patient previously received more than one 14-day treatment course with the requested drug for the current pregnancy/childbirth? **Y** ☐ **N** ☐
7. Is the patient 18 years of age or older? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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