Prescriber Criteria Form Zurzuvae 2025 PA Fax 6282-A v1 010125.docx Zurzuvae (zuranolone) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Zurzuvae (zuranolone).

Drug Name: Zurzuvae (zuranolone)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the requested drug being prescribed for the treatment of postpartum depression (PPD)? [If no, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a confirmed diagnosis of postpartum depression by standardized rating scales that reliably measure depressive symptoms (e.g., Hamilton Depression Rating Scale [HDRS], Edinburgh Postnatal Depression Scale [EPDS], Patient Health Questionnaire 9 [PHQ9], Montgomery-Asberg Depression Rating Scale [MADRS], Beck's Depression Inventory [BDI], etc.)?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____