





**New Hampshire Medicaid Fee-for-Service Program  
Prior Authorization Drug Approval Form  
Zurzuvae™ (zuranolone)**

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**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<sup>2</sup> 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:** \_\_\_\_\_

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