



**New Hampshire Medicaid Fee-for-Service Program
Prior Authorization Drug Approval Form**

Zurzuvae™ (zuranolone)

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: Male Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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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:

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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 m² 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:** _____