

# Zurzuvae Enrollment Form



Fax Referral To: 1-877-232-5455  
Address: 500 Ala Moana Blvd., Bldg 1 Honolulu, HI 96813

Phone: 1-808-254-2727  
NCPDP: 1203417

## Six Simple Steps to Submitting a Referral

### 1 PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  
Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_  
Preferred Contact Methods:  Phone (to primary # provided below)  Text (to cell # provided below)  Email (to email provided below)  
*Note: Carrier charges may apply. By providing the phone number(s) and email address above, you are consenting to receive automated calls, emails and/or text messages from CVS Specialty® about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*  
Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_  
Parent/Caregiver/Legal Guardian Name (Last, First): \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

### 2 PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ State License #: \_\_\_\_\_  
NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ Group or Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_ City, State, ZIP Code: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

### 3 INSURANCE INFORMATION Please fax copy of prescription and insurance cards with this form, if available (front and back)

### 4 DIAGNOSIS AND CLINICAL INFORMATION

#### Diagnosis (ICD-10):

F53.0 Postpartum Depression  Other Code: \_\_\_\_\_ Description \_\_\_\_\_

#### Patient Clinical Information:

Allergies: \_\_\_\_\_

Has patient previously been treated for Postpartum Depression?  Yes  No

If YES, list all previous medications \_\_\_\_\_

List concomitant medications (e.g. adjunctive depression medications): \_\_\_\_\_

**Please Complete Patient and Prescriber Information**

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_

Prescriber Phone: \_\_\_\_\_

**5 PRESCRIPTION INFORMATION**

Treatment information for Prescribers

- o Recommended dosage is 50mg orally once daily in the evening for 14 days
- o *Severe Hepatic Impairment*: Recommended dosage is 30mg orally once daily in evening for 14 days
- o *Moderate or Severe Renal Impairment*: Recommended dosage is 30mg orally once daily in the evening for 14 days

For additional information, please refer to full prescribing information: [Zurzuvae Prescribing Information](#)

**6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)**

Note: The prescription form below should only be used if permitted by the applicable law in your state and if you are not required by law to use an official/tamper-evident prescription form. The prescriber should include all required elements of a controlled substance prescription.

Patient Name (First and Last): \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

Drug Name, Strength and Dosage Form: \_\_\_\_\_

Directions/Sig: \_\_\_\_\_

Quantity Authorized (Numeric) \_\_\_\_\_ (Written) \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber DEA #: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

The information provided above is true and accurate to the best of my knowledge, with supporting documentation in the patient's medical record. By signing below, I hereby authorize CVS Specialty Pharmacy and/or its affiliate pharmacies to complete and submit prior authorization (PA) requests to payors for the prescribed medication for this patient and to attach this Enrollment Form to the PA request as my signature.

**PHYSICIAN SIGNATURE REQUIRED  
STAMP SIGNATURE NOT ALLOWED**

PRODUCT SUBSTITUTION PERMITTED \_\_\_\_\_ (Date) \_\_\_\_\_ DISPENSE AS WRITTEN \_\_\_\_\_ (Date)  
X \_\_\_\_\_ X \_\_\_\_\_

Note: Regulations around transmission of prescriptions for controlled substances vary state by state.

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Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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