Zurzuvae Enrollment Form

CVS specialty®

Fax Referral To: 1-855-297-1270 **Phone:** 1-888-280-1190
Address: 280 Avenida Jesus T. Pinero Ste B Rio Piedras, PR 00927 **NCPDP:** 4026325

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

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