



# Zulresso™ Enrollment Form

Fax Referral To: 1-800-323-2445

Phone: 1-800-678-1831

Email Referral To: [customerservicefax@caremark.com](mailto:customerservicefax@caremark.com)

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

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
 Preferred Contact Methods:  Phone (to primary # provided below)  Text (to cell # provided below)  Email (to email provided below)  
*Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*  
 Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  
 Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

## PRESCRIBER INFORMATION

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

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

Primary Insurance Name: \_\_\_\_\_ Telephone: \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Pharmacy Plan Name: \_\_\_\_\_ Pharmacy Plan Telephone: \_\_\_\_\_  
 Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_ RX BIN #: \_\_\_\_\_ RX PCN #: \_\_\_\_\_

## DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_  
 Ship to: Infusion Site Address: \_\_\_\_\_  
**Note: Zulresso is available only through a restricted distribution program called the ZULRESSO REMS because of the risk of serious harm resulting from excessive sedation and sudden loss of consciousness during the Zulresso infusion. Zulresso is intended for infusion only in a certified Health Care Setting.**

Will REMS certified health care facility dilute and prepare product for infusion administration:  Yes  No  
 If 'No,' does REMS certified health care facility require specialty pharmacy to dilute and prepare Zulresso?  Yes  No

### Diagnosis (ICD-10):

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

For additional ICD-10 information, please visit [CVS Specialty Healthcare Professionals Website](https://www.cvsspecialty.com/wps/portal/specialty/healthcare-professionals/about-us)

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### Patient Clinical Information:

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lb/kg

## TREATMENT INFORMATION FOR PRESCRIBERS

### Before submitting this form, please ensure:

- Provider identifies whether or not specialty pharmacy will dispense diluted and prepared Zulresso for infusion administration
  - Note: If dilution and preparation of Zulresso is required, please ensure prescription order also covers a Curlin 6000 CMS ambulatory infusion pump and tubing
- Copies of the health insurance and prescription drug coverage cards are provided

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# Zulresso™ Enrollment Form

Please complete Patient and Prescriber information

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_  
Prescriber Name: \_\_\_\_\_ Prescriber Phone: \_\_\_\_\_

## TREATMENT INFORMATION FOR PRESCRIBERS continued

### Zulresso prescribing highlights

- Zulresso is administered as a continuous IV infusion over 60 hours as follows:
  - 0 to 4 hours: Initiate with a dosage of 30 mcg/kg/hour
  - 4 to 24 hours: Increase dosage to 60 mcg/kg/hour
  - 24 to 52 hours: Increase dosage to 90 mcg/kg/hour (alternatively consider a dosage of 60 mcg/kg/hour for those who do not tolerate 90 mcg/kg/hour)
  - 52 to 56 hours: Decrease dosage to 60 mcg/kg/hour
  - 56 to 60 hours: Decrease dosage to 30 mcg/kg/hour
- Prior to infusion, each vial of Zulresso must be diluted with 40ml Sterile Water for Injection and 40ml of 0.9 % Sodium Chloride Injection for a total volume of 100ml to achieve a concentration of 1mg/ml.
- After dilution, the product can be stored in infusion bags under refrigerated conditions for up to 96 hours. However, given that the diluted product can be used for only 12 hours at room temperature, each 60-hour infusion will require the preparation of at least 5 infusion bags.

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

## PRESCRIPTION INFORMATION

**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) \_\_\_\_\_

Physician Name: \_\_\_\_\_ Physician DEA #: \_\_\_\_\_

Physician Address: \_\_\_\_\_

### PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

X \_\_\_\_\_ X \_\_\_\_\_

### Prescriber Signature Required (no stamps)

Please note regulations around transmission of prescriptions for controlled substances vary state by state.

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