Zurzuvae Enrollment Form

Fax Referral To: 1-844-850-7915
Escribe ID: 1466033

Phone: 1-866-933-4779

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): ______________________

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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)
X ____

DISPENSE AS WRITTEN (Date)
X ____

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

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