HIGHMARK HEALTH OPTIONS

Updated: 07/2024
Approved: 08/2024

Request for Prior Authorization for Zulresso (brexanolone)
Website Form – www.wv.highmarkhealthoptions.com
Submit request via: Fax - 1-833-547-2030.

All requests for Zulresso (brexanolone) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Zulresso (brexanolone) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of Postpartum Depression (PPD) and the following criteria is met:

- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- Must be ≤ 6 months postpartum
- The member must meet the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) criteria for moderate to severe major depressive disorder with onset of the major depressive episode occurring no earlier than the 3rd trimester and no later than four (4) weeks following delivery.
- Hamilton Rating Scale for Depression (HAM-D) ≥ 20
- Must be prescribed by a psychiatrist
- Member has been counseled on the monitoring requirements and side effects of the medication and has provided consent to treatment
- The member has not previously received either Zulresso OR Zurzuvae (zuranolone) for the current postpartum depressive episode from the most recent pregnancy
- The member does not have any known clinical contraindication to Zulresso.
- The member must not have active untreated substance abuse disorder, active psychosis, schizophrenia, bipolar or schizo-affective disorder
- The healthcare facility and member must be enrolled in Zulresso REMS prior to administration of Zulresso
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 30 days; One time use per pregnancy

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

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ZULRESSO (BREXANOLONE) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (833)-547-2030.**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon-Fri 8:00am to 7:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

☐ Postpartum Depression, ICD-10 Code: _____ ☐ Other: ICD-10 Code:

- How many months postpartum is the member currently? ☐ ≤ 6 months ☐ more than 6 months
- When did symptoms start? ☐ Third trimester ☐ Within 4 weeks of delivery ☐ Other: _____
- HAM-D Score: ☐ 0 - 20 ☐ 20 - 50 _____ _____

Has the member been counseled on the monitoring requirements and side effects and provided consent to treatment?
☐ Yes ☐ No

Has the member previously received either Zulresso or Zurzuvae (zuranolone) for the current postpartum depressive episode?
☐ Yes ☐ No

Doe the member have any known clinical contraindication to Zulresso? ☐ Yes ☐ No

Is the healthcare facility and member enrolled in Zulresso REMS program? ☐ Yes ☐ No

Does the member have active untreated substance abuse disorder, active psychosis, schizophrenia, bipolar or schizo-affective disorder ? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date