TRICARE Prior Authorization Request Form for
zuranolone **(Zurzuvae)**

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 1 year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Zurzuvae.*	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient had a positive response to therapy and the risks of continued therapy do not outweigh the benefits?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Is the patient 18 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have postpartum depression (PPD)? **Note: Use for major depressive disorder is not allowed.**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient 12 months or less postpartum?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**

6. Does the patient have a contraindication to, intolerability to, or has failed a trial of ONE formulary antidepressant medication (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose)? **Examples of formulary antidepressants include:** • selective serotonin reuptake inhibitors (SSRIs, for example, citalopram, escitalopram, fluoxetine, paroxetine, sertraline), • serotonin/norepinephrine reuptake inhibitors (SNRIs, for example, venlafaxine, duloxetine; not including milnacipran), • tricyclic antidepressants (TCAs, for example, amitriptyline, desipramine, imipramine, nortriptyline), • mirtazapine, • bupropion, • trazodone immediate-release, • nefazodone, and • monoamine oxidase inhibitors (MAOIs)	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient use effective contraception during treatment and for one week after the final dose?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[5 December 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: