HIGHMARK WHOLECARE

Updated: 01/2024
PARP Approved: 03/2024

Prior Authorization Criteria

Zulresso (brexanolone) and Zurzuvae (zuranolone)

All requests for Zulresso (brexanolone) and Zurzuvae (zuranolone) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

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 within 12 months postpartum
- Onset of symptoms was in the third trimester or within 4 weeks of delivery
- Hamilton Rating Scale for Depression (HAM-D) ≥ 20
- Must not have a medical history of schizophrenia, bipolar disorder, or schizoaffective disorder
- 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:** 1 week (Zulresso only); 14 days (Zurzuvae only)
- **Reauthorization criteria**
    - One-time use per pregnancy
- **Reauthorization Duration of Approval:** N/A

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.

HIGHMARK WHOLECARE

Updated: 01/2024
PARP Approved: 03/2024

ZULRESSO (BREXANOLONE) AND ZURZUVAE (ZURANOLONE) 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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049

If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (800) 392-1147 Mon – Fri 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
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:	

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:	ICD Code:

Is the member within 12 months postpartum? ☐ Yes ☐ No

Is the onset of symptoms within the third trimester or within 4 weeks of delivery? ☐ Yes ☐ No

What was the Hamilton Rating Scale for Depression (HAM-D)?

Does the member have a medical history of schizophrenia, bipolar disorder, or schizoaffective 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