Updated: 06/2021
DMMA Approved: 07/2021

Request for Prior Authorization for Zulresso (brexanolone)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

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 ≤ 6 months postpartum
- Onset of symptoms was in the third trimester or within 4 weeks of delivery
- Hamilton Rating Scale for Depression (HAM-D) ≥ 20
- Member has been counseled on the monitoring requirements and side effects of the medication and has provided consent to treatment
- 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
- **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.

Highmark Delaware HEALTH OPTIONS

Updated: 06/2021
DMMA Approved: 07/2021

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:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
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 (if medically please provide a 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: _____
- 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

☐ Other: _____ ICD-10 Code: _____

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

Does the member have a 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