

# 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

Facility Type:  Private Practice  Outpatient Hospital/Clinic  Inpatient Facility  Correctional  
Prescriber's First Name: \_\_\_\_\_ Prescriber's Last Name: \_\_\_\_\_  
NPI#: \_\_\_\_\_ State License#: \_\_\_\_\_ DEA#: \_\_\_\_\_  
Practice/Facility Name: \_\_\_\_\_ Practice NPI#: \_\_\_\_\_  
Practice Address (Ship to Address): \_\_\_\_\_ City: \_\_\_\_\_  
State/ZIP Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Office Contact Name: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

### 4 INSURANCE INFORMATION *(Please fax copy of prescription/medical insurance cards with this form, front and back)*

Is the Patient Insured?  Yes  No Is the Patient enrolled or eligible for Medicare/Medicaid?  Yes  No  
Policy Holder's Name: \_\_\_\_\_ Policy Holder's DOB: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_  
Medical Insurance: \_\_\_\_\_ Telephone: \_\_\_\_\_ Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_  
Prescription Insurance: \_\_\_\_\_ Prescription Plan Telephone: \_\_\_\_\_  
Policy ID: \_\_\_\_\_ Group #: \_\_\_\_\_ RX BIN #: \_\_\_\_\_ RX PCN #: \_\_\_\_\_  
 Check box if patient is enrolled in manufacturer copay assistance If yes, please provide ID# \_\_\_\_\_

### 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 (to be completed by prescriber only)

#### 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](#)

**NOTE:** Prescriber must comply with his/her state-specific prescription requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution or any other prescription element which may be required and that is not captured by this form. For this reason, the prescription form below should only be used if permitted by the applicable law in your state. 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): \_\_\_\_\_ Refills: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Prescriber Phone Number: \_\_\_\_\_

Prescriber DEA #: \_\_\_\_\_ State License #: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

Supervising Physician Name: \_\_\_\_\_ Supervising Physician Phone Number: \_\_\_\_\_

Supervising Physician Address: \_\_\_\_\_ Supervising Physician DEA#: \_\_\_\_\_

### 6 PRESCRIBER SIGNATURE REQUIRED (STAMP SIGNATURE NOT ALLOWED)

May Substitute/ Product Selection Permitted /  
Substitution Permissible

Dispense As Written/ Brand Medically Necessary / Do Not Substitute  
/ No Substitution / DAW /  
May Not Substitute

Prescriber's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**CA, MA, NC & PR:** Interchange is mandated unless Prescriber writes the words "No Substitution"

**ATTN: New York and Iowa providers,** please submit electronic prescription

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 above, 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.

I have obtained written authorization from the Patient to disclose the Patient's personal health information and any other information on this enrollment form as may be required to comply with all applicable federal and state laws and regulations, including, but not limited to, the HIPAA Privacy Rule (45 C.F.R. Parts 160 and 164) and the Confidentiality of Substance Use Disorder Patient Records Regulation (42 C.F.R. Part 2), as amended from time to time.

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