**HUSKY Health Program Zulresso™ (brexanolone)**
**Prior Authorization Request Form**
**Phone: 1.800.440.5071**

**THIS FORM IS TO BE COMPLETED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.**

| **Member Information** | | | | |
|---|---|---|---|---|
| Member ID #: | | Member Name (Last, First): | | DOS: |
| DOB: | Sex: | Primary Diagnosis Code: | HCPCS Code: | |
| Address: | | City, State, Zip: | | |

| **Please fill out completely** | | |
|---|---|---|
| 1. Is the individual 15 years of age or older? Age: _____ | ◯ Yes | ◯ No |
| 2. Is there documentation of moderate to severe postpartum depression (a major depressive episode, with onset no earlier than the third trimester, and no later than four weeks after delivery) by standardized rating scales that reliably measure depressive symptoms? ***Please attach results.*** | ◯ Yes | ◯ No |
| 3. Has the diagnosis of postpartum depression been confirmed by a psychiatrist? | ◯ Yes | ◯ No |
| 4. Does the individual have a history of active psychosis, schizophrenia, bipolar disorder, or schizoaffective disorder? | ◯ Yes | ◯ No |
| 5. Has the individual had a suicide attempt during the current episode of postpartum depression? | ◯ Yes | ◯ No |
| 6. Does the individual have a history of alcohol or substance use disorder in the past 12 months? | ◯ Yes | ◯ No |
| 7. Does the individual have a history of seizure disorder? | ◯ Yes | ◯ No |
| 8. Is the individual currently pregnant? | ◯ Yes | ◯ No |
| 9. Will treatment be given in the postpartum period within six months of last delivery? | ◯ Yes | ◯ No |
| 10. What was the date of delivery? | Date: | |
| 11. Has lactation ceased or has the individual agreed that any breast milk produced during treatment with Zulresso will not be used for feedings during the infusion, and for up to four days following infusion completion? | ◯ Yes | ◯ No |
| 12. Does the individual have end stage renal disease (ESRD)? | ◯ Yes | ◯ No |
| 13. Have all other medical and behavioral conditions been addressed and deemed stable by the ordering provider? | ◯ Yes | ◯ No |
| 14. Has a description of the benefits, risks, and treatment expectations been provided to the individual? | ◯ Yes | ◯ No |
| 15. Will the administration follow the current FDA labeling for Zulresso dosing protocol? | ◯ Yes | ◯ No |
| 16. Is the provider or provider's healthcare setting certified in the Zulresso REMS program, with the ability to support ongoing monitoring? | ◯ Yes | ◯ No |

| **Billing Provider Information** | |
|---|---|
| Medicaid Billing #: | Billing Provider Name: |
| Street Address: | City, State, Zip: |
| Contact Name: | Phone #: |
| Fax #: | |

| **Ordering Provider Information** | |
|---|---|
| Medicaid Billing #: | Ordering Provider Name: |
| Street Address: | City, State, Zip: |
| Contact Name: | Phone #: |
| Fax #: | Provider Specialty: |

**Certification Statement:** This is to certify that the requested treatment is medically indicated and is reasonable and necessary for the treatment of this patient, and that a prescribing practitioner-signed order is on file.This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

| Provider Signature: | Date: |
|---|---|
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