# Zurzuvae Enrollment Form

CVS specialty®

**Fax Referral To:** 1-855-297-1270 **Phone:** 1-888-280-1190
**Address:** 6020 Ave Roberto Sanchez Vilella , PR 00982 **NCPDP:** 4026325

## 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:** _____<br>**Date:** _____ | **Prescriber's Signature:** _____<br>**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.