Mountain Pacific
INNOVATING BETTER HEALTH

Mailing Address: P.O. Box 5119 | Helena, MT 59604
Phone: 406.443.6002 | Toll-free: 1.800.395.7961
Fax: 406.513.1928 | Toll-free: 1.800.294.1350

Montana Healthcare Programs Prior Authorization Request Form for Use of Zurzuvae® (zuranolone)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	
Dosage Requested:		

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member is 18 years of age or older: ☐ Yes ☐ No
2. Member has a diagnosis of severe postpartum depression with onset of symptoms during:
   - ☐ Third trimester of pregnancy
   - ☐ Within 4 weeks after delivery – Date of delivery: _____

   Note: Treatment must occur within 12 months of delivery
3. Provider attests that they have reviewed the box warning of impaired ability to drive or engage in other potentially hazardous activities with the member: ☐ Yes ☐ No

LIMITATIONS:
Maximum dose for authorization: Two 25mg (50mg) capsules daily for 14 days

---

☐ CONTINUATION OF THERAPY

Zurzuvae® is indicated for 14 days of treatment only. No renewal will be approved.

Please complete form and fax to
Drug Prior Authorization Unit at 1-800-294-1350.