ZURZUVAE® (zuranolone) capsules CV
20 mg • 25 mg • 30 mg

Referral Form

ZURZUVAE is only available through specialty pharmacies. This form serves as a prescription for ZURZUVAE. Once completed, send this form to a specialty pharmacy listed on the last page and the pharmacy will ship ZURZUVAE directly to your patient.

1. PATIENT INFORMATION *(Complete or include demographic sheet)*

First Name: _____ Middle Initial: ☐ Last Name: _____

DOB: _____ Gender (at birth): ☐ Male ☐ Female

Address: _____

City: _____ State: ☐ ZIP Code: _____ Is this the preferred shipping location? ☐ Yes ☐ No

If no, preferred shipping location:

Address: _____ City: _____ State: ☐ ZIP Code: _____

Preferred Contact Methods: ☐ Phone *(to primary # provided below)* ☐ Text *(to # provided below)* ☐ Email *(to email provided below)*

Note: Carrier charges may apply. By providing the phone number(s) and email address, you are consenting to receive automated calls, emails, and/or text messages 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 4 Digits of SSN: _____ Primary Language: _____

Caregiver: _____ Relationship to Patient: _____

Can this caregiver accept shipment? ☐ Yes ☐ No Primary Phone: _____ Primary Language: _____

2. INSURANCE INFORMATION *(Please fax copy of prescription and insurance cards [front and back] with this form, if available)*

Is the patient insured? ☐ Yes ☐ No Is the Patient Enrolled or Eligible for Medicare/Medicaid? ☐ Yes ☐ No

Primary Policyholder's First Name: _____ Last Name: _____

Policyholder's DOB: _____ Relationship to Patient: _____

Medical Insurance: _____ Phone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Phone: _____

Policy ID: _____ Group #: _____ Rx BIN #: _____ Rx PCN #: _____

Secondary Insurance? ☐ Yes ☐ No

Medical Insurance: _____ Phone: _____ Policy ID: _____ Group #: _____

Prescription Insurance: _____ Prescription Plan Phone: _____

Policy ID: _____ Group #: _____ Rx BIN #: _____ Rx PCN #: _____

3. PRESCRIBER INFORMATION

Facility Type: ☐ Private Practice ☐ Outpatient Hospital/Clinic ☐ Inpatient Facility ☐ Correctional Facility

Prescriber's First Name: _____ Prescriber's Last Name: _____ Prescriber Title: _____

NPI #: _____ State License #: _____ DEA #: _____ State-Controlled Substance Registration #: _____

Practice/Facility Name: _____ Practice NPI #: _____

Practice Address *(as registered with the DEA)*: _____

City: _____ State: _____ ZIP Code: _____ Phone: _____ Fax: _____

Supervising Physician Name: _____ Supervising Physician Phone: _____

Supervising Physician Address: _____ Supervising Physician DEA #: _____

Office Contact Name: _____ Contact Email Address: _____ Contact Phone: _____

4. PRESCRIPTION INFORMATION FOR ZURZUVAE *(To be completed by prescriber only)*

NOTE: Prescriber must comply with state-specific prescription requirements such as state-specific prescription forms, electronic prescribing requirements, product substitution, or any other prescription element that may be required and is not captured by this form. For this reason, the prescription form at left 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.

For additional information, please refer to full Prescribing Information, including BOXED WARNING, at ZURZUVAEhcp.com.

Patient First Name: _____ Patient Last Name: _____ Patient DOB: _____

Patient Address: _____ City: _____ State: _____ ZIP Code: _____

Drug Name, Strength, and Dosage Form: _____

Directions/Sig: _____

Quantity Authorized (Numeric): _____ (Written): _____ Refills: _____

5. PRESCRIBER SIGNATURE REQUIRED *(STAMP SIGNATURE NOT ALLOWED)*

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 below, I hereby authorize Biogen's Pharmacy Network 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 Referral 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 Referral 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.

CONFIDENTIALITY NOTICE: This communication and any attachments may contain confidential and/or privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution, or copying of it or its contents is prohibited. If you have received this communication in error, please notify the sender immediately by phone and destroy all copies of this communication and any attachments.

Plan member privacy is important to us. Our employees are trained regarding the appropriate way to handle members' private health information.

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: _____	**Prescriber's Signature:** _____
Date: _____	**Date:** _____

CA, MA, NC, and PR: Interchange is mandated unless Prescriber writes the words "No Substitution."
ATTN: NY and IA providers, please submit electronic prescription.

REMINDER: Please send copies of both insurance and pharmacy benefit cards (front and back)

6. DIAGNOSIS AND CLINICAL INFORMATION

Patient First Name: _____ Last Name: _____ DOB: _____

Diagnosis (ICD-10): ☐ F53.0

Patient Clinical Information:

Allergies: _____

Has patient previously been treated for this diagnosis? ☐ Yes ☐ No

If Yes, list all previous medications: _____

List concomitant medications: _____

Screening Assessment:

☐ EPDS Score: _____ Date: _____

☐ PHQ-9 Assessment Score: _____ Date: _____

Onset of Symptoms Date: _____ Delivery Date: _____ Symptoms: _____

Prognosis Without Treatment: _____

BIOGEN PHARMACY NETWORK

Specialty pharmacy	NPI/ID number for EHR lookup	Contact information		
Accredo®	4436920	Phone: 800-272-3858	Fax: 888-302-1028	7 AM-7 PM CT
Accredo® Honolulu (Hawaii patients only)	1242293	Phone: 800-272-3858	Fax: 888-302-1028	7 AM-7 PM CT
Alto Pharmacy®	0552403	Phone: 800-874-5881	Fax: 415-484-7058	10 AM-8:30 PM ET
CVS Specialty®	1466033	Phone: 866-993-4779	Fax: 844-850-7915	7 AM-7 PM CT
Special Care Pharmacy Services (Puerto Rico patients only)	205819729	Phone: 888-727-1727	Fax: 787-783-2951	8 AM-5 PM AT
Walmart Specialty Pharmacy	1013934413	Phone: 877-453-4566	Fax: 866-537-0877	7 AM-8:30 PM ET

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