

**IMPORTANT INFORMATION:** Zulresso is a controlled substance. The appropriate prescription, in accordance with state-specific requirements, must be submitted separately from this enrollment form.

## PATIENT INFORMATION *(Complete or include demographic sheet)*

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
 Preferred Contact Methods:  Phone (to primary # provided below)  Text (to cell # provided below)  Email (to email provided below)  
*Note: Carrier charges may apply. If unable to contact via text or email, Specialty Pharmacy will attempt to contact by phone.*  
 Primary Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender:  Male  Female  
 Email: \_\_\_\_\_ Last Four of SSN: \_\_\_\_\_ Primary Language: \_\_\_\_\_

## PRESCRIBER INFORMATION

Prescriber's Name: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
 Practice Address: \_\_\_\_\_ City, State, ZIP: \_\_\_\_\_  
 Group or Hospital: \_\_\_\_\_ NPI #: \_\_\_\_\_ DEA #: \_\_\_\_\_ State License #: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_ Contact's Phone: \_\_\_\_\_

## INSURANCE INFORMATION

Please fax copy of prescription and insurance cards with this form, if available (front and back)

## DIAGNOSIS AND CLINICAL INFORMATION

Needs by Date: \_\_\_\_\_

Ship to: Infusion Site Address: \_\_\_\_\_

**Note:** Zulresso is available only through a restricted distribution program called the ZULRESSO REMS because of the **risk of serious harm resulting from excessive sedation and sudden loss of consciousness during the Zulresso infusion. Zulresso is intended for infusion only in a certified Health Care Setting.**

Will REMS certified health care facility dilute and prepare product for infusion administration:  Yes  No  
 If 'No,' does REMS certified health care facility require specialty pharmacy to dilute and prepare Zulresso?  Yes  No

### Diagnosis (ICD-10):

F53.0 Postpartum Depression  Other Code: \_\_\_\_\_ Description: \_\_\_\_\_

### Patient Clinical Information:

Allergies: \_\_\_\_\_ Height: \_\_\_\_\_ in/cm Weight: \_\_\_\_\_ lb/kg

## PRESCRIBING INFORMATION

### Before submitting this form, please ensure:

- Provider identifies whether or not specialty pharmacy will dispense diluted and prepared Zulresso for infusion administration
  - **Note:** If dilution and preparation of Zulresso is required, please ensure prescription order also covers a CADD Solis CMS ambulatory infusion pump and tubing
- Copies of the health insurance and prescription drug coverage cards are provided

For additional information, please refer to full prescribing information: [Zulresso Prescribing Information](#)

<input type="checkbox"/> Zulresso	100mg/20ml Vial	Infuse IV - 0-4hr - 30mcg/kg/hr; 4-24hr - 60mcg/kg/hr; 24-52hr - 90mcg/kg/hr; 52-56hr - 60mcg/kg/hr; 56-60hr - 30mcg/kg/hr	Continuous Pulse Oximetry Monitor
<b>Premedication(s):</b> <input type="checkbox"/> Diphenhydramine 25-50 mg po – 25mg #2 per dose <input type="checkbox"/> Acetaminophen 325-650 mg po – 325mg #2 per dose <input type="checkbox"/> Methylprednisolone _____mg IV over _____mins <input type="checkbox"/> Other: _____		<b>Ancillary Orders:</b> <input type="checkbox"/> NaCl 0.9% 5-10ml IV before and after infusion <input type="checkbox"/> Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN <input type="checkbox"/> Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN <input type="checkbox"/> All infusion supplies necessary to administer the medication <input type="checkbox"/> Anaphylaxis Kit	

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (XSIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing TwelveStone to serve as my prior authorization agent with medical and pharmacy insurance providers

Physician's Phone #	Physician's NPI#	Physician's Fax #	Physician's Address
<input checked="" type="checkbox"/> Dispense as Written	Date	Physician DEA#	