Zulresso™ Enrollment Form

Fax Referral To: 1-615-278-3355 **Phone: 1-844-893-0012** **Email Referral To: intake@12stonehealth.com**

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

☐ 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	

Premedication(s):

- ☐ Diphenhydramine 25-50 mg po – 25mg #2 per dose
- ☐ Acetaminophen 325-650 mg po – 325mg #2 per dose
- ☐ Methylprednisolone_____mg IV over_____mins
- ☐ Other: _____

Ancillary Orders:

- ☐ NaCl 0.9% 5-10ml IV before and after infusion
- ☐ Heparin 10 units/ml 3-5ml IV after infusion for peripheral access and PRN
- ☐ Heparin 100 units/ml 3-5ml IV after infusion for central IV access and PRN
- ☐ All infusion supplies necessary to administer the medication
- ☐ 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
_____ XDispense as Written	_____ Date	_____ Physician DEA#	

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