CVS specialty®

Zulresso Enrollment Form

Fax Referral To: 1-800-323-2445 Phone: 1-800-678-1831 Email Referral To: Customer.ServiceFax@CVSHealth.com

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)

Primary Insurance Name: _____ Telephone: _____ Policy ID: _____ Group #: _____

Pharmacy Plan Name: _____ Pharmacy Plan Telephone: _____

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

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

TREATMENT INFORMATION FOR PRESCRIBERS

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 Curlin 6000 CMS ambulatory infusion pump and tubing
- Copies of the health insurance and prescription drug coverage cards are provided

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Please complete Patient and Prescriber information

Patient Name: _____ Patient DOB: _____

Prescriber Name: _____ Prescriber Phone: _____

TREATMENT INFORMATION FOR PRESCRIBERS continued

Zulresso prescribing highlights

- Zulresso is administered as a continuous IV infusion over 60 hours as follows:
  - 0 to 4 hours: Initiate with a dosage of 30 mcg/kg/hour
  - 4 to 24 hours: Increase dosage to 60 mcg/kg/hour
  - 24 to 52 hours: Increase dosage to 90 mcg/kg/hour (alternatively consider a dosage of 60 mcg/kg/hour for those who do not tolerate 90 mcg/kg/hour)
  - 52 to 56 hours: Decrease dosage to 60 mcg/kg/hour
  - 56 to 60 hours: Decrease dosage to 30 mcg/kg/hour
- Prior to infusion, each vial of Zulresso must be diluted with 40ml Sterile Water for Injection and 40ml of 0.9 % Sodium Chloride Injection for a total volume of 100ml to achieve a concentration of 1mg/ml.
- After dilution, the product can be stored in infusion bags under refrigerated conditions for up to 96 hours. However, given that the diluted product can be used for only 12 hours at room temperature, each 60-hour infusion will require the preparation of at least 5 infusion bags.

For additional information, please refer to full prescribing information: Zulresso Prescribing Information

PRESCRIPTION INFORMATION

NOTE: The prescription form below should only be used if permitted by the applicable law in your state and if you are not required by law to use an official/tamper-evident prescription form. 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) _____

Physician Name: _____ Physician DEA #: _____

Physician Address: _____

PHYSICIAN SIGNATURE REQUIRED

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

X_____ X_____

Prescriber Signature Required (no stamps)

Please note regulations around transmission of prescriptions for controlled substances vary state by state.

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. 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 telephone 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. This document contains references to brand-name prescription drugs that are trademarks or registered trademarks of pharmaceutical manufacturers not affiliated with CVS Pharmacy, Inc. or one of its affiliates. 75-49131A 020921