Brexanolene (ZULRESSO) therapy treatment request

Instructions: Please complete all the fields in treatment request form. Please use the checklist when submitting TRICARE referrals through provider self-service at **HumanaMilitary.com** to ensure that all necessary clinical information is included and to expedite authorization process.

Does the beneficiary have a history of Brexanolone (ZULRESSO)? If so, please provide the following information:

- Indicate if this is an initial, concurrent or continued Brexanolone (ZULRESSO) request
- Response to treatment
- Date
- Frequency

List and describe trials of failed antidepressants:

- Name of medication
- Classification (SSRI, SNRI, TCA, MAOI, etc.)
- Duration
- Dosage
- Response to medication

Describe the desired observable outcomes and indicate whether the beneficiary agrees with the treatment goals.

If any of the following are present, please indicate on the referral/authorization request:

- If beneficiary is suffering from End-Stage Renal Disease (ESRD), provide Estimated Glomerular Filtration Rate (eGFR)
- Severe cardiovascular disease
- Pregnant or breastfeeding
- Excessive use of alcohol or illicit substances within the past 30 days
- Use of opioids, antidepressants or other Central Nervous System (CNS) depressants such as benzodiazepines or alcohol
- Concurrent review only: indicate a worsening of postpartum depression or new or worse suicidal thoughts

Note: Beneficiary should be enrolled in Risk Evaluation and Mitigation Strategy (REMS) program at time of treatment

Note: Provider resource: National Pregnancy Registry for Antidepressants (NPRAD) at (844) 405-6185 or **womensmentalhealth.org/research/pregnancyregistry/antidepressants**

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Please use provider self-service at **HumanaMilitary.com** for TRICARE referrals, or fax to (877) 378-2316.

Date submitted: _____

Beneficiary information

Patient name: Mitch _____ ☐ M ☐ F DOB: _____

Patient ID or SSN: _____ Active Duty Service Member (ADSM): ☐ Yes ☐ No

Address: _____

City: _____ State: _____ ZIP Code: _____

DoD benefit #: _____ Phone #: _____

Referring provider

Provider name: _____ TIN/NPI: _____

Military hospital or clinic/eMSM: _____ TIN/NPI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone #: _____ Fax #: _____

Servicing provider

Provider type: ☐ Medical Doctor (MD) ☐ Doctor of Osteopathic Medicine (DO)

Administering provider name: _____ Administering provider TIN/NPI: _____

Provider REMS name: _____ Provider REMS number: _____

Provider REMS enrolled date: _____ REMS program TIN/NPI: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone #: _____ Fax #: _____

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Background information

Current psychiatric and medical conditions

Diagnosis (DSM-5-TR/ICD-10)	Onset	Description (include symptoms, treatment, etc.)

Current clinical symptoms

Symptom	Onset	Description

Current medications

Medication	Psychotropic	Medical	Prescribing MD	PCM	Psychiatrist	Other
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐

Are there any warnings given for these medications for specific diagnostic populations? ☐ Y ☐ N If no, please describe below:

_____

History of ZULRESSO? ☐ Y ☐ N If yes, please describe: _____

Describe beneficiary response to ZULRESSO per evidenced-based rating tool	Name of evidenced-based rating tool	Date administered

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Please list and describe trials of failed antidepressants including classification (SSRI, SNRI, TCA, MAOI, etc.)

Medication	Class	Duration	Dosage	Response to medication

Was the depression inventory tool completed? ☐ Y ☐ N

If yes, provide score and date: Score _____ Date_____

If this is a concurrent review, provide result score and date of both baseline and most recent assessment:

Score _____ Date_____

Please provide a description of psychotherapy treatments in the previous 12 months

Psychotherapy	Date of treatment

Service request information

Anticipated start date:_____ Anticipated completion date: _____

Location: ☐ Inpatient ☐ Outpatient ☐ Combination

Beneficiary agrees with treatment goals? ☐ Y ☐ N

CPT code	Units	Frequency	Additional comments

Would this be the beneficiary's initial ZULRESSO treatment? ☐ Y ☐ N

If no, would this be a concurrent treatment or continuation of treatment? Please explain and provide last date of treatment:

_____

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Desired observable outcomes:

Please respond to the following and mark all that apply:

☐ If beneficiary is suffering from ESRD, provide eGFR

☐ Severe cardiovascular disease

☐ Pregnant or breastfeeding

☐ Excessive use of alcohol or illicit substances within the last 30 days

☐ Use of opioids, antidepressants or other CNS depressants, such benzodiazepines or alcohol

☐ (Concurrent review only) Worsening of postpartum depression or new or worse suicidal thoughts

Signature indicates that the beneficiary is physically and intellectually capable to actively participate in all aspects of the therapeutic program.

Provider signature _____ Date _____