South Dakota Department of Social Services

DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-22941

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WEB: DSS Medicaid Prior Authorizations | **EMAIL :** DSSMedicaidpa@state.sd.us

ZULRESSO PRIOR AUTHORIZATION REQUEST FORM

This form **MUST BE** submitted with medical records to support services

Date:		
RECEIPIENT INFORMATION		
Medicaid ID:	**Date of Birth:**	**Sex:** M ☐ F ☐
Last Name:	**First Name:**	
GENERAL INFORMATION		
First Date of Service:	**Last Date of Service:**	
Primary Diagnosis Code:	**HCPC Code:**	
Drug Name:	**Quantity:**	
Hospitalizations/Treatments/Medications Used in the last 6 months:		
POINT OF CONTACT		
Name and Title:		
Email:	**Phone:**	**Fax:**
Note: *The point of contact is the individual completing the PA and would be the contact for questions SD Medicaid may have regarding the PA. The determination notice will be sent to the listed point of contact.*		
REFERRING PROVIDER INFORMATION		
Name:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	
SERVICING PROVIDER INFORMATION		
Name:		
Address:		
NPI #:	**Taxonomy:**	
Phone:	**Fax:**	

CRITERIA		
☐	**Medical records to support use of product are submitted**	
Initial Therapy (check one)	**Yes** ☐	**No** ☐
☐	Therapy is prescribed by or in consultation with a psychiatrist	
☐	Individual is ≤6 months postpartum	
☐	Individual has a diagnosis of severe depression as indicated by DSM-5 criteria and/or an appropriate depression rating scale (ex. HAM-D, MADRS, PHQ-9, etc.)	
☐	Individual has previously failed therapy after a 60 day trial with at least **one** medication from the following classes: ☐ Selective Serotonin Reuptake Inhibitor (SSRI) ☐ Selective Norepinephrine Reuptake Inhibitor (SNRI) ☐ Tricyclic Antidepressant (TCA) ☐ Bupropion	
☐	Individual is ≥15 years of age	
☐	Individual has not received prior treatment with Zulresso or Zurzuvae for the current pregnancy	
PHYSICIAN SIGNATURE – PROVIDER ONLY		
This form must be signed by a provider		
☐	I certify that the information given in this form is a true and accurate medical indication for the required product	
Name & Title (Printed):		**Specialty:**
Signature:		