Field Name	Field Description
Prior Authorization Group Description	**Zulresso (brexanolone)**
Drugs	Zulresso (brexanolone)
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Patient must be 15 years of age or older
Prescriber Restrictions	Prescriber must be a psychiatrist or an obstetrician-gynecologist
Coverage Duration	If all the criteria are met, the initial request will be approved for a one – time infusion per postpartum period. Continuation after the initial infusion is not indicated for this medication.
Other Criteria Revision/Review Date 10/2023	**<u>Initial Authorization:</u>** • Diagnosis of moderate to severe postpartum depression (PPD) confirmed by a rating scale such as Montgomery-Åsberg Depression Rating Scale (MADRS) or the Hamilton Rating Scale for Depression (HAM-D) with a score of ≥ 20 • Patient is ≤ 12 months postpartum with onset of a major depressive episode between the third trimester and 4 weeks after delivery • Healthcare facility and patient must be enrolled in the Zulresso REMS program prior to initiation of medication • Patient's weight has been provided and dosing is consistent with FDA approved labeling **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

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Prior Authorization Group Description	**Zulresso (brexanolone)**
Drugs	Zulresso (brexanolone)
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Exclusion Criteria	N/A
Required Medical Information	See "Other Criteria"
Age Restrictions	Patient must be 15 years of age or older
Prescriber Restrictions	Prescriber must be a psychiatrist or an obstetrician-gynecologist
Coverage Duration	If all the criteria are met, the initial request will be approved for a one – time infusion per postpartum period. Continuation after the initial infusion is not indicated for this medication. ~~If all the above criteria are not met, the request must be referred to a Clinical Reviewer for a medical necessity review.~~
Other Criteria Revision/Review Date 10/~~2022~~2023	**Initial Authorization:** • Diagnosis of moderate to severe postpartum depression (PPD) confirmed by a rating scale such as Montgomery-Åsberg Depression Rating Scale (MADRS) or the Hamilton Rating Scale for Depression (HAM-D) with a score of ≥ 20 • Patient is ≤ 12 months postpartum with onset of a major depressive episode between the third trimester and 4 weeks after delivery • Healthcare facility and patient must be enrolled in the Zulresso REMS program prior to initiation of medication • Patient's weight has been provided and dosing is consistent with FDA approved labeling **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**

PerformRx recommends approving the Zulresso prior authorization criteria with no clinical changes for ACOH.