

Fax Referral To: 1-800-323-2445

Zulresso[™] Enrollment Form

Phone: 1-800-678-1831 Email Referral To: customerservicefax@caremark.com

PATIENT INFORMA					
Patient Name: Preferred Contact Methods:	· ·	Address:	City	, State, ZIP:	
Preferred Contact Methods:	Phone (to prima	ary # provided below) 🗌 Te	xt (to cell # provide	d below) 🗌 Email	I (to email provided below
Note: Carrier charges may a	apply. If unable to c	ontact via text or email, Spe	cialty Pharmacy wil	ll attempt to conta	ct by phone.
Primary Phone:	Alternate	Phone:	_ DOB:	Gender	r: 🔄 Male 🔄 Female
Email:		Last Four of SSN:	Prima	ary Language:	
PRESCRIBER INFO	RMATION				
Prescriber's Name:		Practice	Name:		
	Name: Practice Name: ress: City, State, ZIP:				
Group or Hospital:		NPI #:	DEA #:	State Lice	ense #:
Phone:	Fax	Contact Person	:	Contact's Ph	ione:
INSURANCE INFOR			d inguranaa aarda y	with this form if a	vailable (front and back)
Primary Insurance Name:		l'elephone:	P		Group #:
Pharmacy Plan Name:				_ Pharmacy Plan Telephone: #: RX PCN #:	
Policy ID:		Group #:	RX BIN #:	R>	K PCN #:
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Please complete Patient and Prescriber information				
Patient Name:	Patient DOB:			
Prescriber Name:	Prescriber Phone:			

Zulresso™ Enrollment Form

TREATMENT INFORMATION FOR PRESCRIBERS continued

Zulresso prescribing highlights

- Zulresso is administered as a continuous IV infusion over 60 hours as follows:
 - \circ ~ 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)
 - o 52 to 56 hours: Decrease dosage to 60 mcg/kg/hour
 - o 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) X	DISPENSE AS WRITTEN (Date) X				

Prescriber Signature Required (no stamps)

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

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