US Family Health Plan
Prior Authorization Request Form for
Norethindrone Acetate / Ethinyl estradiol ODT (Femlyv)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. The provider acknowledges that other formulations of ethinyl estradiol (EE) 20 mcg/ norethindrone 1 mg (for example, Loestrin, Aurovela, Microgestin, Junel, Larin or equivalent) are on the formulary and do not require prior authorization.	☐ Acknowledged Proceed to question **2**	
2. The provider acknowledges that there are chewable contraceptive tablets (norethindrone 1 mg/EE 20 mcg/iron (for example, Charlotte 24 Fe, Finzala, Mibelas 24 Fe); norethindrone 0.8mg/EE 25 mcg (for example, Kaitlib Fe, Layolis Fe); norethindrone 0.4mg/EE 35 mcg/iron (for example, Wymzya Fe)) and alternate dosage forms (etonogestrel/EE ring (generic NuvaRing); norelgestromin/EE patch (Xulane, Zafemy); and medroxyprogesterone acetate injection (generic Depo-Provera) on the formulary that do not require prior authorization.	☐ Acknowledged Proceed to question **3**	
3. Has the patient tried and failed or has a relative contraindication to a contraceptive from one of the following classes: chewable, patch, ring, injection, or IUD?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient require oral disintegrating tablets and can neither chew nor swallow due to some documented medical condition (for example, developmental disability, muscular weakness, etc.) and not due to convenience?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[12 February 2025]