US Family Health Plan
Prior Authorization Request Form for elagolix/estradiol/norethindrone (**Oriahnn**), relugolix/estradiol/norethindrone (**Myfembree**)

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 expires after 24 months (lifetime expiration)

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. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the patient a premenopausal woman with diagnosed heavy menstrual bleeding associated with uterine leiomyomas (fibroids)? **Note: Non-FDA-approved uses are not approved including pain associated with endometriosis.**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had inadequate relief after at least three months of first-line therapy with a hormonal contraceptive or Intrauterine Device (IUD)?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed by a reproductive endocrinologist or obstetrics/gynecology specialist?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient pregnant?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **6**

6. Has it been confirmed that the patient is not pregnant by (-) HCG?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient use non-hormonal contraception throughout treatment and for one week after discontinuation of treatment?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have current or history of thrombotic or thromboembolic disorders or an increased risk for these events?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Is the patient a smoker over the age of 35?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Does the provider agree to discontinue treatment if a thrombotic, cardiovascular, or cerebrovascular event occurs or if the patient has a sudden unexplained partial or complete loss of vision, proptosis (abnormal protrusion of the eye), diplopia (double vision), papilledema (optic disc swelling), or retinal vascular lesions?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Does the patient have uncontrolled hypertension?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. Does the provider agree to monitor blood pressure and discontinue treatment if blood pressure rises significantly?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Does the patient have osteoporosis?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **14**
14. Does the provider agree to advise the patient to seek medical attention for suicidal ideation, suicidal behavior, new onset or worsening depression, anxiety, or other mood changes?	☐ Yes Proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Does the patient have a history of breast cancer or other hormonally-sensitive malignancies?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **16**
16. Does the patient have known liver impairment or disease?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **17**

17. Does the provider agree to counsel patients on the signs and symptoms of liver injury?	☐ Yes Proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Does the patient have undiagnosed abnormal uterine bleeding?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **19**
19. Will the cumulative treatment with Oriahnn and Myfembree exceed 24 months during the patient's lifetime?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **20**
20. What is the requested medication?	☐ Oriahnn Proceed to question **21**	☐ Myfembree Proceed to question **22**
21. Is the patient using Oriahnn concomitantly with cyclosporine or gemfibrozil or other organic anion transporting polypeptide [(OATP)1B1] inhibitors?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**
22. Is the patient using Myfembree with oral P-gp inhibitors (for example, erythromycin) or combined P-gp and strong CYP3A inducers (for example, rifampin)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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

Prescriber Signature _____ Date _____