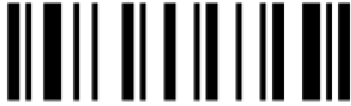
TRICARE Prior Authorization Request Form for

relugolix **(Orgovyx)**



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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) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

PLEASE NOTE: For Active Duty Service Members, even if coverage will NOT BE APPROVED per this form, it still must be initially submitted to the TPharm Contractor for review. Subsequent reconsideration is allowed at the appropriate Military Treatment Facility.

For initial review by the TPharm Contractor;

- The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477**
- The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: **TPharmPA@express-scripts.com**

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:

Question		
1. The provider is aware and acknowledges that leuprolide acetate SQ (Eligard), and degarelix SQ (Firmagon) are available to DoD beneficiaries without requiring prior authorization. Please consider changing the prescription to one of these agents.	☐ Acknowledged Proceed to Question **2**	
2. Is the patient 18 years of age or older?	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. Is the requested medication prescribed by or in consultation with an oncologist or urologist?	☐ Yes Proceed to Question **4**	☐ No **STOP** **Coverage not approved**
4. What is the indication or diagnosis? **Note: Non-FDA approved uses are NOT approved including cancers other than prostate cancer, and in women for endometrial thinning, endometriosis, and uterine leiomyomata (fibroids).**	☐ Advanced prostate cancer - Proceed to Question **7** ☐ Other - Proceed to Question **5**	

Question		
5. Please provide the indication or diagnosis.	______________________ Proceed to question **6**	
6. Is the diagnosis cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed leuprolide acetate SQ (Eligard) or degarelix SQ (Firmagon)?	☐ Yes **Sign and date below**	☐ No Proceed to Question **8**
8. Does the patient have significant cardiovascular risk factors as determined by an oncologist or urologist?	☐ Yes **Sign and date below**	☐ No Proceed to Question **9**
9. Is the patient prescribed short-term androgen deprivation therapy (ADT)?	☐ 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

[3 January 2024]