US Family Health Plan
Prior Authorization Request Form for
Relugolix (Orgovyx)

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**

Clinical documentation may be required for approval.
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 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**	

TRICARE Prior Authorization Request Form for
relugolix **(Orgovyx)**

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]