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**

Medical documentation may be required. Failure to provide could result in denial.

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 following agents are available without a prior authorization: leuprolide acetate IM (Lupron Depot), leuprolide acetate SQ (Eligard), and degarelix SQ (Firmagon). 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 in women for endometrial thinning, endometriosis, and uterine leiomyomata (fibroids).**	☐ Advanced prostate cancer - Proceed to Question **7** ☐ Other - Proceed to Question **5**	
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 an injectable formulation (for example, subcutaneous injection or implant, intramuscular injection)?	☐ Yes **Sign and date below**	☐ No Proceed to Question **8**

	8. Is the patient unable to use an injectable formulation (for example, subcutaneous injection or implant, intramuscular injection)?	☐ 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 _____