US Family Health Plan
Prior Authorization Request Form for
fezolinetant (**Veozah**)

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:**

Question	Yes	No
1. Has the patient received this medication under the USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Veozah.*	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient had a positive response to therapy as noted by a decrease in the number of moderate to severe hot flashes?	☐ Yes **Sign and date on page 2**	☐ No **STOP** **Coverage not approved**
3. Does the patient have moderate to severe vasomotor symptoms due to menopause?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have an average of 7 to 8 moderate to severe hot flashes per day or 50 to 60 hot flashes per week?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient have a contraindication to menopausal hormone therapy (estrogens with or without progestins)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Does the patient have an intolerance to menopausal hormone therapy?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**

7. Is the patient unwilling to take menopausal hormone therapy after a shared medical decision-making discussion has occurred?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have severe renal impairment (eGFR of 15 to 30 mL/min/1.73m2) or end-stage renal disease (eGFR less than 15 mL/min/1.73m2)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Does the patient have cirrhosis?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Does the provider acknowledge that patient's baseline hepatic function will be evaluated via bloodwork prior to therapy, at 3 months, at 6 months, at 9 months and when symptoms suggest hepatic injury?	☐ 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

[30 June 2023]