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**

Initial therapy approves for 6 months, renewal approves indefinitely.
For renewal of therapy, an initial USFHP prior authorization approval is required.

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. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE 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 a contraindication to menopausal hormone therapy (estrogens with or without progestins)?	☐ Yes Proceed to question **7**	☐ No Proceed to question **5**
5. Does the patient have an intolerance to menopausal hormone therapy?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**
6. Based on individual patient characteristics and risk factors, has the provider determined that the patient is not a candidate for menopausal hormone therapy?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Has the patient tried and failed or had an adverse reaction to at least one of the following non-hormonal treatments for vasomotor symptoms: an SSRI (for example, paroxetine, escitalopram, or citalopram), an SNRI (for example, venlafaxine, desvenlafaxine, or duloxetine), OR gabapentin?	☐ 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, monthly for the first 3 months, at 6 months, at 9 months and when symptoms suggest hepatic injury?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has the provider advised the patient to stop taking Veozah immediately and seek medical attention if they experience signs or symptoms that may suggest liver injury (for example, new onset fatigue, nausea, vomiting, pruritus, jaundice, pale feces, dark urine, or right upper quadrant pain)?	☐ 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 _____

[24 Sept 2024]