TRICARE Prior Authorization Request Form for
norethindrone acetate/ethinyl estradiol ODT **(Femlyv)**

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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 acknowledges that other formulations of ethinyl estradiol (EE) 20 mcg/ norethindrone 1 mg (for example, Loestrin, Aurovela, Microgestin, Junel, Larin or equivalent) are on the formulary and do not require prior authorization.	☐ Acknowledged Proceed to question **2**	
2. The provider acknowledges that there are chewable contraceptive tablets (norethindrone 1 mg/EE 20 mcg/iron (for example, Charlotte 24 Fe, Finzala, Mibelas 24 Fe); norethindrone 0.8mg/EE 25 mcg (for example, Kaitlib Fe, Layolis Fe); norethindrone 0.4mg/EE 35 mcg/iron (for example, Wymzya Fe)) and alternate dosage forms (etonogestrel/EE ring (generic NuvaRing); norelgestromin/EE patch (Xulane, Zafemy); and medroxyprogesterone acetate injection (generic Depo-Provera) on the formulary that do not require prior authorization.	☐ Acknowledged Proceed to question **3**	
3. Has the patient tried and failed or has a relative contraindication to a contraceptive from one of the following classes: chewable, patch, ring, injection, or IUD?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient require oral disintegrating tablets and can neither chew nor swallow due to some documented medical condition (for example, developmental disability, muscular weakness, etc.) and not due to convenience?	☐ 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

[12 February 2025]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: