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

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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 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**	

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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]

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