TRICARE Prior Authorization Request Form for
Fezolinetant (**Veozah**)

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.

Initial therapy approves for 6 months, renewal approves indefinitely. For renewal of therapy, an initial Tricare 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**

TRICARE Prior Authorization Request Form for Fezolinetant (**Veozah**)

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 _____

[15 Nov 2023]

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