

SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is not complete, correct, or legible, authorization may be delayed.

Drug Requested: Veozah[®] (fezolinetant)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Weight: _____ Date: _____

Recommended Dosage: One Tablet Daily

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Member has a diagnosis of moderate to severe vasomotor symptoms due to menopause
- Member has had baseline blood work to evaluate hepatic function and injury prior to start of treatment and will perform follow-up bloodwork at 3 months, 6 months, and 9 months after initiation of therapy and when symptoms suggest liver injury
- Member does **NOT** have cirrhosis
- Member does **NOT** have a diagnosis of severe renal impairment or end-stage renal disease
- Member is **NOT** receiving simultaneous treatment with CYP1A2 inhibitors

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- ❑ Member must meet **ONE** of the following:
 - ❑ Member has tried and failed **30 days of therapy** with **TWO** hormonal medications (e.g., oral estrogen tablets/topical transdermal patch; **verified by chart notes or pharmacy paid claims**)
 - ❑ Member has tried and failed **30 days of therapy** with **ONE** non-hormonal medication (e.g., SNRI, SSRI, gabapentin, clonidine, oxybutynin; **verified by chart notes or pharmacy paid claims**)

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****