SENTARA COMMUNITY PLAN
(MEDICAID)

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 the information provided is not complete, correct, or legible, the authorization process can 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 Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

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.*

***Approved by Pharmacy and Therapeutics Committee:** 8/16/2023
REVISED/UPDATED/REFORMATTED: 6/10/2024