

AvMed

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 1-305-671-0200.** 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:

<input type="checkbox"/> Lynkuet [®] (elinzanetant)	<input type="checkbox"/> Veozah [®] (fezolinetant)
--	---

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

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Weight (if applicable): _____ Date weight obtained: _____

Quantity Limit:

- Lynkuet – 2 (60 mg) capsules per day
- Veozah – 1 (45 mg) tablet per day

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

(Continued on next page)

- ❑ Member must meet **ONE** of the following:
 - ❑ **For Lynkuet requests:** Provider attests 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 after initiation of therapy
 - ❑ **For Veozah requests:** Provider attests 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 if/when symptoms suggest liver injury
- ❑ Provider attests member does **NOT** have any of the following contraindications to therapy:
 - ❑ **For Lynkuet requests:** Member is not pregnant
 - ❑ **For Veozah requests:** Member does not have cirrhosis, a diagnosis of severe renal impairment or end-stage renal disease, and is not receiving concomitant therapy with CYP1A2 inhibitors
- ❑ 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.