

Myfembree (relugolix/estradiol/norethindrone acetate)

Prior Authorization Request Form

Caterpillar Prescription Drug Benefit

Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTOR (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? <input type="checkbox"/> YES (if yes, complete below) <input type="checkbox"/> NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:
2. LIST DIAGNOSES:		ICD-10:
<input type="checkbox"/> Uterine Fibroids <input type="checkbox"/> Endometriosis <input type="checkbox"/> Other diagnosis: _____ ICD-10: _____		
3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.		
Clinical Information: Is the patient pre-menopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No For <u>diagnosis of uterine fibroids</u>, please answer the following: Does the patient have a diagnosis of uterine fibroids? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(Please submit a copy of the ultrasound report.)</i> Is the prescriber an OB/GYN specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No Does the patient have a history of osteoporosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient had prior use of Oriahnn (elagolix/estradiol/norethindrone)? <input type="checkbox"/> Yes <input type="checkbox"/> No For <u>diagnosis of endometriosis</u>, please answer the following: Does patient have a diagnosis of endometriosis with surgical or direct visualization and/or histopathological confirmation? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Does patient have chronic pelvic pain caused by another condition outside confirmed endometriosis? <input type="checkbox"/> Yes <input type="checkbox"/> No Does patient have a history of or currently have osteoporosis or another metabolic bone disease? <input type="checkbox"/> Yes <input type="checkbox"/> No Has patient tried and failed or had an intolerance to or has an absolute contraindication to at least one prior therapy of hormonal contraceptive therapy, progestin therapy, gonadotropin-releasing hormone (Gn-RH), an aromatase inhibitor or surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Please submit documentation.</i> Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review? _____ _____		
Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.		

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ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811