Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Veozah (fezolinetant) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 3 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Veozah (fezolinetant).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours (fax: 1-866-331-2104). If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is the prescriber an OB/GYN or Gynecologic Oncology specialist?
   □ No □ Yes

2. Is the patient's age <65 years?
   □ No □ Yes

3. Does the patient have a documented diagnosis of moderate to severe menopausal vasomotor symptoms (VMS)?
   □ No □ Yes

4. Does the patient have ANY of the following at baseline?
   a. Cirrhosis
   b. ALT, AST, or bilirubin ≥ 2x ULN
   c. Severe renal impairment (eGFR < 30 mL/min/1.73 m^2) or end-stage renal disease
   d. Uncontrolled HTN (or ≥2 blood pressure readings >130/80 mmHg in past 1 month)
   e. Concomitant use with CYP1A2 inhibitor(s) (e.g., acyclovir, ciprofloxacin, estradiol, propranolol, verapamil, etc.)

   □ No □ Yes

5. Is there documentation that patient is unable to use OR has contraindication to hormonal therapy?
   □ No □ Yes

6. Does the patient have documented inadequate response, intolerance, or contraindication to <u>3 or more</u> of the following non-hormonal therapies?
   a. SNRI (e.g., desvenlafaxine, duloxetine, venlafaxine XR)
   b. SSRI (e.g., citalopram, escitalopram, paroxetine)
   c. Clonidine
   d. Gabapentin
   e. Oxybutynin

   □ No □ Yes

7. Is the initial prescription limited to a maximum of 30-day supply with 2 refills?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below:

1. Is there documentation of continued need for VMS treatment?
   □ No □ Yes

2. Is there documentation of 50% reduction in frequency OR severity of VMS after initiating fezolinetant?
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**