Prior Authorization Form

CAREFIRST

Myfembree

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Myfembree.

Drug Name (select from list of drugs shown)
Myfembree (relugolix-estradiol-norethindrone)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for the management of heavy menstrual bleeding associated with uterine leiomyomas (fibroids) in a premenopausal patient?	Y N
[If no, then no further questions.]	
2. Has the patient previously received treatment with an elagolix-containing product (e.g., Oriahnn, Orilissa) or a relugolix-containing product (e.g., Myfembree)?	Y N
[If no, then no further questions.]	
3. Has the patient already received any of the following: A) Greater than or equal to 24 cumulative months of treatment	Y N

with elagolix-containing products (e.g., Oriahnn, Orilissa) and/or relugolix-containing products (e.g., Myfembree), B) Greater than or equal to 6 months of treatment with Orilissa 200mg twice daily?	
[If yes, then no further questions.]	
4. How many cumulative months has the patient received treatment with elagolix-containing products (e.g., Oriahnn, Orilissa) and/or relugolix-containing products (e.g., Myfembree)?	
[Note: Please check the total cumulative months of treatment.]	
12 months or less (if checked, no further questions)	☐
13 months (if checked, no further questions)	☐
14 months (If checked, no further questions)	☐
15 months (if checked, no further questions)	☐
16 months (if checked, no further questions)	☐
17 months (if checked, no further questions)	☐
18 months (if checked, no further questions)	☐
19 months (if checked, no further questions)	☐
20 months (if checked, no further questions)	☐
21 months (if checked, no further questions)	☐
22 months (if checked, no further questions)	☐
23 months (if checked, no further questions)	☐
24 months or greater (if checked, no further questions)	☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date