



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  $\geq$  2x ULN
  - c. Severe renal impairment (eGFR < 30 mL/min/1.73 m<sup>2</sup>) or end-stage renal disease
  - d. Uncontrolled HTN (or  $\geq$  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 3 or more 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 additional questions 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:**

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

<b>Prescriber Signature:</b>	<b>Date:</b>
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