PRIOR AUTHORIZATION REQUEST

Veozah

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No
3	Does the patient have a previously approved prior authorization (PA) on file with the current plan for the requested medication?	Yes	No

If you have any questions, call:
1-888-258-8250

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PRIOR AUTHORIZATION REQUEST

	[Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan that has expired within the past forty-five OR will expire within the next thirty days, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]		
4	Has the patient been diagnosed with moderate to severe vasomotor symptoms due to menopause? [If no, no further questions.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	Has the patient been diagnosed with moderate to severe vasomotor symptoms due to menopause? [If no, no further questions.]	Yes	No
8	Has the patient experienced a minimum of 7 episodes of moderate to severe vasomotor symptoms per day for the last 3 months? [If no, no further questions.]	Yes	No
9	Does the patient have any known contraindications (cirrhosis, severe renal impairment, end stage renal disease, drug interactions) to the requested medication? [If yes, no further questions.]	Yes	No
10	Has baseline blood work been conducted to evaluate for hepatic function and injury prior to treatment initiation? [If no, no further questions.]	Yes	No
11	Is the patient being concurrently treated with a CYP1A2 inhibitor medication? [If yes, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has a trial and failure with at least THREE formulary hormonal replacement agents for at least 3 months, or experienced intolerable adverse effects or contraindication to three hormonal replacement therapies? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has documentation been submitted to confirm that the patient has a trial and failure with at least TWO other oral medications used to treat moderate to severe	Yes	No

PRIOR AUTHORIZATION REQUEST

vasomotor symptoms due to menopause for at least 3 months, or experienced intolerable adverse effects or contraindication to TWO non-hormonal replacement therapies? ACTION REQUIRED: Submit supporting documentation.

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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