HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
MYFEMBREE® FOR HEALTHY U

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Myfembree® (relugolix/estradiol/norethindrone)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Does the member have diagnosis of heavy menstrual bleeding associated with uterine leiomyomas (fibroids)?	☐	☐	
2. Does documentation show heavy menstrual bleeding?	☐	☐	**Please provide documentation**
3. Has the diagnosis of uterine leiomyomas (fibroids) been confirmed by pelvic ultrasound?	☐	☐	**Please provide documentation**
4. Is the member a premenopausal female ≥18 years of age?	☐	☐	
5. Is the request made by, or in consultation with, an obstetrician/gynecologist or reproductive endocrinologist?	☐	☐	
6. Has the member had a three-month trial and failure of, or contraindication/intolerance, to all of the following: • Combination estrogen –progestin contraceptives used as continuous therapy • Progestin monotherapy (intrauterine device, injection, or oral) • Tranexamic acid	☐	☐	**Please provide documentation**
7. Has the member received 24 months of therapy with a GnRH agent?	☐	☐	
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does the member have a continued need for therapy?	☐	☐	**Please provide documentation**

3. Does documentation show the therapy is effective and tolerable?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

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Policy PHARM- HU001
Origination Date: 10/05/2021
Reviewed/Revised Date: 10/13/2021
Next Review Date: 10/13/2022
Current Effective Date: 11/01/2021