**CAREFIRST**
**Myfembree**

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

## Patient Information

**Patient Name:**

**Patient Phone:** ☐☐☐ - ☐☐☐ - ☐☐☐☐

**Patient ID:**

**Patient Group:**

**Patient DOB:** ☐☐ / ☐☐ / ☐☐☐☐

## Physician Information

**Physician Name**

**Physician Phone:** ☐☐☐ - ☐☐☐ - ☐☐☐☐

**Physician Fax:** ☐☐☐ - ☐☐☐ - ☐☐☐☐

**Physician Addr.:**

**City, St, Zip:**

## Drug Name (select from list of drugs shown)

Myfembree (relugolix-estradiol-norethindrone)

**Quantity:** _____ **Frequency:** _____ **Strength:** _____

**Route of Administration:** _____ **Expected Length of Therapy:** _____

**Diagnosis:** _____ **ICD Code:** _____

**Comments:** _____

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## Please check the appropriate answer for each applicable 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** ☐ |
| 2. | Is the requested drug being prescribed for the management of moderate to severe pain associated with endometriosis in a premenopausal patient? | **Y** ☐ | **N** ☐ |
| 3. | Has the patient received the maximum recommended treatment course of 12 months of Lupron Depot or Lupaneta Pack OR 6 months of Synarel or Zoladex? | **Y** ☐ | **N** ☐ |
| 4. | 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** ☐ |
| 5. | Has the patient already received ANY of the following: A) Greater than or equal to 24 cumulative months of treatment with an elagolix-containing product (e.g., Oriahnn, Orilissa) and/or a relugolix-containing product (e.g., Myfembree), B) Greater than or equal to 6 months of treatment with Orilissa 200 mg twice daily? | **Y** ☐ | **N** ☐ |
| 6. | How many cumulative months has the patient received treatment with an elagolix-containing product (e.g., Oriahnn, Orilissa) and/or a relugolix-containing product (e.g., Myfembree)? 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.

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**Prescriber (Or Authorized) Signature and Date**