OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare

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Orgovyx™ (Relugolix) Prior Authorization Form

Member Name:_____ **Date of Birth:**_____ **Member ID#:**_____

Drug Information

Pharmacy billing (NDC:_____**)** ***Start Date (or date of next dose):***_____

Dose:_____ ***Regimen:***_____

Billing Provider Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Pharmacy Phone:_____ ***Pharmacy Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____ ***Specialty:***_____

Criteria

For Initial Authorization:

1. Please indicate the diagnosis and information:
   - ☐ **Prostate Cancer**
     - A. Is disease advanced? Yes☐ No☐
     - B. Please provide a patient-specific, clinically significant reason why the member cannot use Eligard® (leuprolide acetate):

       _____

       _____
     - C. Please provide a patient-specific, clinically significant reason why the member cannot use Firmagon® (degarelix):

       _____

       _____
     - D. Please provide a patient-specific, clinically significant reason why the member cannot use Lupron Depot® (leuprolide acetate):

       _____

       _____
   - ☐ **If diagnosis is not listed of the above, please indicate diagnosis:**_____

For Continued Authorization:

1. Date of last dose:_____
2. Does patient have any evidence of progressive disease while on relugolix therapy? Yes☐ No☐
3. Has the member experienced any adverse drug reactions related to relugolix therapy? Yes☐ No☐

If yes, please specify adverse reactions:_____

Prescriber Signature:_____ **Date:**_____

I certify that the indicated treatment is medically necessary and all information is true and correct to the best of my knowledge. *Please do not send in chart notes. Specific information will be requested if necessary. Failure to complete this form in full will result in processing delays.*

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/ Oklahoma.**	