OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare

# 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.*

| PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO: | CONFIDENTIALITY NOTICE |
|---|---|
| University of Oklahoma College of Pharmacy<br>Pharmacy Management Consultants<br>Product Based Prior Authorization Unit<br><br>Fax: 1-800-224-4014<br>Phone: 1-800-522-0114 Option 4 | *This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.* |