CONSIDERATIONS FOR COMPLETING A PRIOR AUTHORIZATION APPEAL

Myfembree®
(relugolix, estradiol, and norethindrone acetate) tablets
40 mg, 1 mg, 0.5 mg

This resource is intended as educational support to assist providers who would like to complete a prior authorization appeal. The provider has the responsibility to ensure correct policies are followed. Providers must ensure they accurately complete and submit necessary information to payers. Use of these tips or the checklist does not guarantee that the health plan will provide reimbursement for medication, nor are they intended to be a substitute for, or influence on, providers' independent medical judgment.

Information on Completing Appeals

- When a patient's health plan has prior authorization criteria requirements that must be met before a Myfembree® prescription is covered, a request with appropriate clinical support should be submitted to the health plan for approval. If a patient's authorization for medication is denied, you may be able to appeal the decision
- The requirements for an appeal submission may vary by health plan and may require filling out a unique form specific to the plan
- A letter reviewing the patient's case, as well as the reasoning behind the treatment appeal, should be included. A sample appeal letter is available through the Myfembree® Support Program. **Please note**: This template is for reference only; it is the prescriber's responsibility to complete the letter based on his or her independent medical judgment
- It is important to keep track of all relevant ID numbers. Since they already appear on the prior authorization request, the numbers should be verified for correctness. The claim number of the rejection should be included as well
- As with a prior authorization request, anticipated response time should be verified/confirmed, and follow-ups with the office should be scheduled to ensure that an appeal has been received and is being reviewed
- Any additional clinical or diagnostic information that was not included in the initial prior authorization submission may be added. The Myfembree package insert must be provided if it was not included in the original submission
- Some health plans may require that a diagnosis be provided by an OB/GYN
- The list below is meant as a resource to help providers complete a prior authorization appeal and is not exhaustive. It is important to be familiar with all of a health plan's appeal requirements

Appeal Checklist

- ☐ Verification of health plan's appeal submission criteria and indication of specialist type (such as OB/GYN)
- ☐ The original rejected authorization form
- ☐ Completed appeal form from health plan (if applicable)
- ☐ Appeal letter
- ☐ Confirmation of previous treatment failures (if applicable)
- ☐ Confirmation with health plan if an appeal is necessary or if it is acceptable to resubmit the prior authorization with completed information
- ☐ Correct contact information for the office
- ☐ Myfembree package insert and other supporting documentation (blood tests, etc)
- ☐ Call to health plan to verify successful submission
- ☐ Call to health plan to check status of submission/response

The Myfembree Support Program includes assistance with prescription coverage appeals. To find out more, please visit www.Myfembreehcp.com or call 1-833-MYFEMBREE (1-833-693-3627), 8 AM – 8 PM ET, Monday – Friday.

Please see full Prescribing Information, including BOXED WARNING.

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