UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

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| Program Number | 2024 P 2312-3 |
| Program | Prior Authorization/Medical Necessity |
| Medication | Veozah™ (fezolinetant) |
| P&T Approval Date | 8/2023, 8/2024, 11/2024 |
| Effective Date | 2/1/2025 |

**1. Background:**

Veozah (fezolinetant) is a neurokinin 3 (NK3) receptor antagonist indicated for the treatment of moderate to severe vasomotor symptoms due to menopause.

Veozah use has been associated with reports of hepatotoxicity in post marketing studies that gradually resolve after discontinuation of Veozah. Baseline hepatic laboratory tests should be evaluated prior to initiation of Veozah.

**2. Coverage Criteria[a]:**

**A. Initial Authorization**

1. **Veozah** will be approved based on **all** of the following criteria:

   a. Diagnosis of moderate to severe vasomotor symptoms due to menopause

   **-AND-**

   b. History of failure (after a 30-day trial), contraindication or intolerance to **one** of the following:

      1) Hormonal therapy (e.g., estradiol, Premarin, Prempro)
      2) Non-hormonal therapy [e.g., clonidine, gabapentin, selective serotonin inhibitors (e.g., paroxetine), serotonin and norepinephrine reuptake inhibitors (e.g., venlafaxine)]

      **-AND-**

   c. Patient has received baseline hepatic laboratory tests to rule out the presence of underlying liver disease

**Authorization will be issued for 12 months.**

**B. Reauthorization**

1. **Veozah** will be approved based on both of the following criteria:

   a. Documentation of positive clinical response to therapy (e.g., decrease in frequency and severity of vasomotor symptoms from baseline)

   -AND-

b. Patient has received periodic evaluation of hepatic laboratory tests to rule out liver injury associated with Veozah use

**Authorization will be issued for 12 months.**

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.

**4. References:**


1. Veozah [package insert]. Northbrook, IL: Astellas US LLC. August 2024.
2. Khan, SJ, Kapoor, E, Faubion, SS, Kling, JM. Vasomotor Symptoms During Menopause: A Practical Guide on Current Treatments and Future Perspectives. *Int J Womens Health.*2023: 15: 273-87.


| Program | Prior Authorization/Medical Necessity - Veozah |
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| **Change Control** | |
| 8/2023 | New program. |
| 8/2024 | Annual review. Updated references. |
| 11/2024 | Added criteria for hepatic laboratory tests and updated references. |