Louisiana Medicaid
Fezolinetant (Veozah®)

The *Louisiana Uniform Prescription Drug Prior Authorization Form* should be utilized to request clinical authorization for fezolinetant (Veozah®).

Additional Point-of-Sale edits may apply.

By submitting the authorization request, the prescriber attests to the conditions available HERE.

Approval Criteria for Initiation of Therapy

- The recipient is 18 years of age or older on the date of the request; **AND**
- The recipient has a diagnosis of moderate to severe vasomotor symptoms associated with menopause; **AND**
- The recipient has tried and failed hormonal therapy for symptoms **OR** a patient-specific, clinically significant reason why the recipient cannot use menopausal hormone therapy is provided; **AND**
- The prescriber **states on the request** that baseline hepatic laboratory tests were performed to evaluate recipient's hepatic function prior to initiation of therapy; **AND**
- The prescriber **states on the request** that hepatic laboratory testing will be performed monthly for the first 3 months, at 6 months, and at 9 months of treatment.

Duration of approval for initiation of therapy: 6 months

Approval Criteria for Continuation of Therapy

- The prescriber **states on the request** that the recipient is established on the medication with evidence of a positive response to therapy which must be described on the request (i.e. vasomotor symptom reduction); **AND**
- The prescriber **states on the request** that repeat hepatic laboratory tests were performed to evaluate recipient's hepatic function within the last 6 months while on Veozah® (Dates of hepatic function tests must be **stated on the request**).

Duration of approval for continuation of therapy: 12 months

Reference

Veozah (fezolinetant) [package insert]. Northbrook, IL: Astellas Pharma US, Inc; December 2024. https://www.astellas.com/us/system/files/veozah_uspi.pdf

Revision / Date	Implementation Date
Policy Created / March 2025	August 2025