AETNA BE	TTER	HEALTH®		* ae	etna [™]			
Coverage Policy/Guideline								
Name: Veozah (fezo		inetant)	Page	e:	1 of 2			
Effective Date: 5/28/2025			Last	Review Date:	5/2025			
Applies to:	⊠Illinois		□Floric	la	□New Jersey			
	⊠Maryland		⊠Florio	da Kids	⊠Pennsylvania Kids			
	□Michigan		⊠Virgiı	nia				

Intent:

The intent of this policy/guideline is to provide information to the prescribing practitioner outlining the coverage criteria for Veozah under the patient's prescription drug benefit.

Description:

FDA-Approved Indication

Veozah is indicated for the treatment of moderate to severe vasomotor symptoms due to menopause.

Applicable Drug List:

Veozah

Policy/Guideline:

Coverage Criteria

Vasomotor Symptoms

Authorization may be granted when the requested drug is being prescribed for the treatment of moderate to severe vasomotor symptoms due to menopause.

Continuation of Therapy

Vasomotor Symptoms

Authorization may be granted when the requested drug is being prescribed for the treatment of moderate to severe vasomotor symptoms due to menopause when ALL of the following criteria are met:

- The patient has achieved or maintained a positive clinical response to the requested drug.
- The patient has been re-evaluated periodically to determine if treatment is still medically necessary.

Approval Duration and Quantity Restrictions:

Initial and Renewal Approval: 12 months **Quantity Level Limit:** 30 tablets per 30 days

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Applies to:	⊠Illinois ⊠Maryland □Michigan		□Florida ⊠Florida Kids ⊠Virginia	□New Jersey ⊠Pennsylvania Kids	

References:

- 1. Veozah [package insert]. Northbrook, IL: Astellas Pharma US, Inc.; December 2024.
- 2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online. Waltham, MA: UpToDate, Inc.; 2024. https://online.lexi.com. Accessed November 29, 2024.
- 3. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/ (cited: 11/29/2024).