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Osphena (Ospemifene) Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004 or Provider Help Desk 1-800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #:_____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Non-Preferred □ Osphena	_____	_____	Specify: _____
7. Diagnosis: _____			

8. Approval criteria: Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.

Prior authorization (PA) is required for ospemifene (Osphena). Requests for a diagnosis of moderate to severe dyspareunia are considered not medically necessary and will be denied. Payment will be considered under the following conditions:

1. Patient is a post-menopausal woman with a diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy; **and**
2. Patient has documentation of an adequate trial and therapy failure with a preferred vaginal estrogen agent; **and**
3. Patient does not have any contraindications to ospemifene as listed in the FDA approved label; **and**
4. Will not be used with estrogens, estrogen agonist/antagonists, fluconazole, or rifampin; **and**
5. Patient does not have severe hepatic impairment (Child-Pugh Class C); **and**
6. Patient will be evaluated periodically as clinically appropriate to determine if treatment is still necessary as ospemifene should be used for the shortest duration consistent with treatment goals and risks for the individual woman; **and**
7. Dose does not exceed the FDA approved dose.

The required trials may be overridden when documented evidence that use of these agents would be medically contraindicated is provided.

Is patient post-menopausal?
☐ Yes ☐ No

Does patient have contraindications to ospemifene as listed in the FDA approved label?
☐ Yes ☐ No

Will ospemifene be used with estrogens, estrogen agonist/antagonists, fluconazole or rifampin?
☐ Yes ☐ No

Does patient have severe hepatic impairment (Child-Pugh Class C)?
☐ Yes ☐ No

Will patient be evaluated periodically to determine if treatment with ospemifene is still necessary?
☐ Yes ☐ No

Preferred vaginal estrogen agent trial:
Drug name and dose: _____
Trial dates: _____Failure reason: _____
_____

Medical or contraindication reason to override trial requirements: _____
_____
_____

Renewals:
Document clinical response to therapy: _____
_____
_____

9. Physician signature

_____ _____
Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.