AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Osphena® (ospemifene)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Patient is a post-menopausal woman diagnosed with moderate to severe dyspareunia due to vulvar and vaginal atrophy (VVA) associated with menopause or moderate to severe vaginal dryness, symptoms of VVA, associated with menopause

AND

- ❑ Patient has trial and failure of **30 days of therapy** with **TWO (2)** of the following medications:
  - ❑ Premarin vaginal cream
  - ❑ generic Alora patches
  - ❑ Estradiol tablets
  - ❑ Premphase tablets
  - ❑ Prempro tablets
  - ❑ Premarin tablets
  - ❑ generic Climara patches

Not all drugs may be covered under every Plan
If a drug is non-formulary on a Plan, documentation of medical necessity will be required.
*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****
****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: 10/15/2015
REVISED/UPDATED: ~~10/23/2015; 12/22/2015; 12/19/2016; 8/15/2017; (Reformatted) 6/19/2019;08/31/2020;~~ **10/30/2023**