



Please note: All information below is required to process this request.  
 Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern



## Osphena® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NP#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information <small>(required)</small>					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
Clinical Information <small>(required)</small>					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Moderate to severe dyspareunia due to vulvar and vaginal atrophy associated with menopause					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Clinical information:</b>					
Is the patient a post-menopausal woman? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>Select if the patient has had a trial and failure of <u>30 days</u> of therapy with the following medications:</b>					
<input type="checkbox"/> Estradiol tablets					
<input type="checkbox"/> Generic Alora patches					
<input type="checkbox"/> Generic Climara patches					
<input type="checkbox"/> Premarin tablets					
<input type="checkbox"/> Premarin vaginal cream					
<input type="checkbox"/> Premphase tablets					
<input type="checkbox"/> Prempro tablets					
<b>**Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.**</b>					
<b>*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*</b>					
Prescriber Signature: _____			Date: _____		

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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