

Request for Prior Authorization Ospemifene (Osphena)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

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 is provided that use of these agents would be medically contraindicated.

Initial requests will be approved for three months. Additional PAs will be considered upon documentation of clinical response to therapy.

Non-Preferred

Osphena

Strength

Dosage Instructions

Quantity

Days Supply

Diagnosis: _____



FAX Completed Form To
 1.833.404.2392
Pharmacy Help Desk
 1.800.460.8988
Prescriber Help Desk
 1.833.587.2012

**Request for Prior Authorization
 Ospemifene (Osphena) - Continued**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

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: _____

Prescriber signature (Must match prescriber listed above.)	Date of submission
--	--------------------

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.