



**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
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**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.