

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: **Commercial (Traditional)** **Commercial (Individual/Optimized)**
 Medicaid

This request is: **Urgent** (life threatening) **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Intrarosa[®] (prasterone)

Member

Last Name: _____ First Name: _____
ID #: _____ DOB: _____ Gender: _____
Primary Care Physician: _____
Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
Provider Address: _____
Provider NPI: _____ Contact Name: _____
Provider Signature: _____ Date: _____

Product Information

New request Continuation request

Drug Product: Intrarosa 6.5 mg vaginal insert

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Patient must meet all of the following criteria:

1. Plan documents must have oral sexual dysfunction rider
2. Diagnosis of moderate to severe dyspareunia caused by vulvovaginal atrophy
3. Documented trial with an OTC vaginal lubricants for at least 90 days
4. Documented trial of vaginal estrogen product for at least 90 days

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. Does the patient have moderate to severe dyspareunia secondary to vulvovaginal atrophy?

- Yes
 No, rationale for use: _____

B. Has the patient had a trial of over the counter vaginal lubricants for at least 90 days?

- Yes
 No, rationale for use: _____

C. Has the patient had a trial of vaginal estrogen for at least 90 days?

- Yes
 No

D. Which of the following drugs has the patient tried?

	Dose	Dates	Outcome
<input type="checkbox"/> Premarin	_____	_____	_____
<input type="checkbox"/> Estrace	_____	_____	_____
<input type="checkbox"/> Estring	_____	_____	_____
<input type="checkbox"/> Vagifem	_____	_____	_____