PriorityHealth

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 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, r*ationale for use:* _____

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

☐ Yes

☐ No, r*ationale for use:* _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018

Last reviewed 09/2019

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
☐ Premarin			
☐ Estrace			
☐ Estring			
☐ Vagifem			

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Updated 05/2013
Last reviewed 09/2018