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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Climara Pro[®] Prior Authorization Request Form

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

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Prophylaxis of postmenopausal osteoporosis</p> <p><input type="checkbox"/> Vasomotor symptoms (moderate to severe) associated with menopause</p> <p><input type="checkbox"/> Vulvar and vaginal atrophy (moderate to severe) associated with menopause</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p>The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.</p> <p>Risk acknowledgment:</p> <p>Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the provider wish to proceed with the originally prescribed medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.</p> <p>Postmenopausal osteoporosis, prophylaxis:</p> <p>Select the medications the patient has a failure, contraindication, or intolerance to:</p> <p><input type="checkbox"/> Alendronate</p> <p><input type="checkbox"/> Fosamax Plus D</p> <p><input type="checkbox"/> Ibandronate</p> <p><input type="checkbox"/> Raloxifene</p> <p><input type="checkbox"/> Risedronate</p> <p><input type="checkbox"/> Risedronate DR</p> <p>Vulvar and vaginal atrophy (moderate to severe) associated with menopause:</p> <p>Select the medications the patient has a failure, contraindication, or intolerance to:</p> <p><input type="checkbox"/> Estring (estradiol vaginal ring)</p> <p><input type="checkbox"/> Premarin vaginal cream</p>

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

Please note: This request may be denied unless all required information is received.
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
 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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
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