



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

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

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

Premarin® Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
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)

Continuation of therapy:
 Is this a continuation of prior therapy? Yes No
 If yes, is it within the past 120 days? Yes No

Select the diagnosis below:

Advanced androgen-dependent carcinoma of the prostate (for palliation only)
 Hypoestrogenism due to hypogonadism, castration, or primary ovarian failure
 Metastatic breast cancer (for palliation only)
 Prophylaxis of postmenopausal osteoporosis
 Vasomotor symptoms (moderate to severe) associated with menopause
 Vulvar and vaginal atrophy (moderate to severe) associated with menopause
 Other diagnosis: _____ ICD-10 Code(s): _____

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.

Risk acknowledgment:
 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? Yes No
 Does the provider wish to proceed with the originally prescribed medication? Yes No

Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.

Hypoestrogenism due to hypogonadism, castration, or primary ovarian failure:
Select the medications the patient has a failure, contraindication, or intolerance to:

<input type="checkbox"/> Estradiol (generic Climara)	<input type="checkbox"/> Estradiol tablet (generic Estrace)
<input type="checkbox"/> Estradiol (generic Minivelle)	<input type="checkbox"/> Estropipate
<input type="checkbox"/> Estradiol (generic Vivelle Dot)	<input type="checkbox"/> Menest

Postmenopausal osteoporosis, prophylaxis:
Select the medications the patient has a failure, contraindication, or intolerance to:

<input type="checkbox"/> Actonel	<input type="checkbox"/> Estradiol (generic Minivelle)	<input type="checkbox"/> Fosamax Plus D
<input type="checkbox"/> Alendronate	<input type="checkbox"/> Estradiol (generic Vivelle Dot)	<input type="checkbox"/> Ibandronate
<input type="checkbox"/> Atelvia	<input type="checkbox"/> Estradiol tablet (generic Estrace)	<input type="checkbox"/> Menest
<input type="checkbox"/> Binosto	<input type="checkbox"/> Estropipate	<input type="checkbox"/> Raloxifene
<input type="checkbox"/> Boniva	<input type="checkbox"/> Femring	<input type="checkbox"/> Risedronate
<input type="checkbox"/> Evista	<input type="checkbox"/> Fosamax	<input type="checkbox"/> Risedronate delayed-release (DR)
<input type="checkbox"/> Estradiol (generic Climara)		

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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Premarin[®] Prior Authorization Request Form (Page 2 of 2)

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Vasomotor symptoms (moderate to severe) associated with menopause:

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Estradiol (generic Climara) | <input type="checkbox"/> Estradiol tablet (generic Estrace) | <input type="checkbox"/> Estropipate |
| <input type="checkbox"/> Estradiol (generic Minivelle) | <input type="checkbox"/> Femring | <input type="checkbox"/> Menest |
| <input type="checkbox"/> Estradiol (generic Vivelle Dot) | | |

Vulvar and vaginal atrophy (moderate to severe) associated with menopause:

Select the medications the patient has a failure, contraindication, or intolerance to:

- | | | |
|---|---|---|
| <input type="checkbox"/> Estrace cream | <input type="checkbox"/> Estradiol (generic Minivelle) | <input type="checkbox"/> Estropipate |
| <input type="checkbox"/> Estradiol vaginal cream (generic Estrace) | <input type="checkbox"/> Estradiol (generic Vivelle Dot) | <input type="checkbox"/> Premarin vaginal cream |
| <input type="checkbox"/> Estradiol vaginal tablet (generic Vagifem) | <input type="checkbox"/> Estring (estradiol vaginal ring) | <input type="checkbox"/> Vagifem |
| <input type="checkbox"/> Estradiol tablet (generic Estrace) | <input type="checkbox"/> Femring | <input type="checkbox"/> Yuvaferm |
| <input type="checkbox"/> Estradiol (generic Climara) | <input type="checkbox"/> Menest | |

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- Titration or loading-dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify:** _____
- Other: _____

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.

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