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

Vivelle-Dot® (estradiol transdermal patch)
Prior Authorization Request Form (Page 1 of 2)

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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
- ❑ Hypoestrogenism due to hypogonadism, castration, or primary ovarian failure
- ❑ 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:
- ❑ Estradiol (generic Climara)
- ❑ Estradiol (generic Minivelle)
- ❑ Estradiol (generic Vivelle Dot)
- ❑ Estradiol tablet (generic Estrace)
- ❑ Estropipate
- ❑ Menest
- ❑ Premarin tablet

Postmenopausal osteoporosis, prophylaxis:
Select the medications the patient has a failure, contraindication, or intolerance to:
- ❑ Alendronate
- ❑ Binosto
- ❑ Estradiol (generic Climara)
- ❑ Estradiol (generic Minivelle)
- ❑ Estradiol (generic Vivelle Dot)
- ❑ Fosamax Plus D
- ❑ Ibandronate
- ❑ Raloxifene
- ❑ Risedronate
- ❑ Risedronate delayed-release (DR)

Vivelle-Dot® (estradiol transdermal patch)
Prior Authorization Request Form (Page 2 of 2)

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Vasomotor symptoms (moderate to severe) associated with menopause:
Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Elestrin
- ❑ Estradiol (generic Climara)
- ❑ Estradiol (generic Minivelle)
- ❑ Estradiol (generic Vivelle Dot)
- ❑ Estradiol tablet (generic Estrace)
- ❑ Estropipate
- ❑ Femring
- ❑ Menest
- ❑ Premarin tablet

Vulvar and vaginal atrophy (moderate to severe) associated with menopause:
Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Estradiol (generic Climara)
- ❑ Estradiol (generic Minivelle)
- ❑ Estradiol (generic Vivelle Dot)
- ❑ Estradiol vaginal cream (generic Estrace)
- ❑ Estradiol vaginal tablet (generic Vagifem)
- ❑ Estring (estradiol vaginal ring)
- ❑ Femring
- ❑ Premarin vaginal cream
- ❑ Yuvafem

Quantity limit requests:

What is the quantity requested per MONTH? _____

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.