Request for Prior Authorization
Ospemifene (Osphena)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (877) 733-3195
IOWA Provider Services
1 (844) 236-1464

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for ospemifene (Osphena). Requests for a diagnosis of moderate to severe dyspareunia are considered not medically necessary and will be denied. Payment will be considered under the following conditions:

1) Patient is a post-menopausal woman with a diagnosis of moderate to severe vaginal dryness due to vulvar and vaginal atrophy; and
2) Patient has documentation of an adequate trial and therapy failure with a preferred vaginal estrogen agent; and
3) Patient does not have any contraindications to ospemifene as listed in the FDA approved label; and
4) Will not be used with estrogens, estrogen agonist/antagonists, fluconazole, or rifampin; and
5) Patient does not have severe hepatic impairment (Child-Pugh Class C); and
6) Patient will be evaluated periodically as clinically appropriate to determine if treatment is still necessary as ospemifene should be used for the shortest duration consistent with treatment goals and risks for the individual woman; and
7) Dose does not exceed the FDA approved dose.

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Initial requests will be approved for three months. Additional PAs will be considered upon documentation of clinical response to therapy.

Non-Preferred

☐ Osphena

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Request for Prior Authorization
Ospemifene (Osphena) *(Continued)*

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Is patient post-menopausal?

☐ Yes ☐ No

Does patient have contraindications to ospemifene as listed in the FDA approved label?

☐ Yes ☐ No

Will ospemifene be used with estrogens, estrogen agonist/antagonists, fluconazole or rifampin?

☐ Yes ☐ No

Does patient have severe hepatic impairment (Child-Pugh Class C)?

☐ Yes ☐ No

Will patient be evaluated periodically to determine if treatment with ospemifene is still necessary?

☐ Yes ☐ No

Preferred vaginal estrogen agent trial:

Drug name and dose:_____

Trial dates:_____ Failure reason:_____

_____

Medical or contraindication reason to override trial requirements:_____

_____

_____

Renewals:

Document clinical response to therapy:_____

_____

_____

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*