

VASOMOTOR SYMPTOMS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermy meds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Vasomotor symptoms <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was the treatment started on samples? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient currently stable on the requested agent? Please note, chart notes are required. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient at risk if therapy is changed? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify risk: _____ _____	
2. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____	
3. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____	
For vasomotor symptoms requests: 4. Is the patient menopausal? <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Are the patient’s symptoms moderate to severe (i.e., 7 or more episodes per day or 50 or more episodes per week)? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Has the patient’s baseline (prior to starting the requested agent) hepatic function (i.e., serum ALT, serum AST, serum ALP, serum bilirubin [total and direct]) been evaluated? <input type="checkbox"/> Yes <input type="checkbox"/> No 7. Are the patient’s hepatic transaminases AND total bilirubin are less than 2 times the upper limit of normal (ULN)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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8. Is the patient 60 years of age or older? Yes No
- If no, **please answer the following questions and submit chart notes to support the answers:**
- Did the patient have an onset of menopause that was at least 10 years prior? Yes No
 - Has the patient tried and had an inadequate response to ONE hormonal therapy (i.e., estrogen therapy [ET] or estrogen plus progesterone therapy [EPT] including oral, transdermal patches, sprays and gels, and vaginal ring agents) used to treat vasomotor symptoms of menopause? Yes No
 - Does the patient have an intolerance or hypersensitivity to ONE hormonal therapy used to treat vasomotor symptoms of menopause? Yes No
 - Does the patient have an FDA labeled contraindication to ALL hormonal therapies used to treat vasomotor symptoms of menopause? Yes No

Please submit chart notes to support the answers to the following questions:

9. Has the patient tried and had an inadequate response to ONE nonhormonal therapy (i.e., paroxetine, escitalopram, citalopram, venlafaxine, desvenlafaxine, duloxetine, gabapentin, oxybutynin) used to treat vasomotor symptoms of menopause? Yes No
10. Was ONE nonhormonal therapy (i.e., paroxetine, escitalopram, citalopram, venlafaxine, desvenlafaxine, duloxetine, gabapentin, oxybutynin) used to treat vasomotor symptoms of menopause discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
11. Does the patient have an intolerance or hypersensitivity to ONE nonhormonal therapy used to treat vasomotor symptoms of menopause? Yes No
12. Does the patient have an FDA labeled contraindication to ALL nonhormonal therapies used to treat vasomotor symptoms of menopause? Yes No
13. Is ONE nonhormonal therapy used to treat vasomotor symptoms of menopause expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
14. Is ONE nonhormonal therapy used to treat vasomotor symptoms of menopause not in the best interest of the patient based on medical necessity? Yes No
15. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE nonhormonal therapy used to treat vasomotor symptoms of menopause and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No

For renewal requests:

16. Has the patient had clinical benefit with the requested agent? Yes No
17. Has the patient's hepatic function (i.e., serum ALT, serum AST, serum ALP, serum bilirubin [total and direct]) been evaluated since starting the requested agent? Yes No
18. Are the patient's hepatic transaminases less than 5 times the upper limit of normal (ULN)? Yes No
19. Are the patient's hepatic transaminase elevations less than 3 times the ULN AND the total bilirubin level is less than 2 times the ULN? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **BCBSIL: 800.285.9426**
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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