PRIOR AUTHORIZATION REQUEST

Duavee

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. ❑ Yes ❑ No Does the patient have an intact uterus?
2. What is the diagnosis/indication?
   - ❑ Vasomotor symptoms associated with menopause (VMS) → ***please proceed to question 3***
   - ❑ Postmenopausal osteoporosis → ***please answer questions 4-10***
   - ❑ All other diagnosis/indication ***(please specify):***_____
3. ❑ Yes ❑ No Has the patient failed OR has intolerance to AT LEAST 2 formulary estrogen/progestin products (such as, estradiol tablets/patch, prempro, estrace)?
4. ❑ Yes ❑ No Has the patient tried and failed raloxifene AND alendronate?
5. ❑ Yes ❑ No Does the patient have a contraindication or intolerance to raloxifene AND alendronate?
6. ❑ Yes ❑ No Does the patient have osteopenia (T-score between -1.0 and -2.5)?
7. ❑ Yes ❑ No Is the patient at high risk for OP fracture that is defined as a FRAX risk GREATER THAN or EQUAL to 3.0% for hip fracture?
8. ❑ Yes ❑ No Is the patient at high risk for any major OP-related fracture?
9. ❑ Yes ❑ No Is the patient at high risk for OP fracture that has a risk factor for fracture which is GREATER THAN or EQUAL to 1 for the following: 1) low body mass index, 2) previous fragility fracture, 3) parental history of hip fracture, 4) glucocorticoid treatment, 5) current smoking, 6) alcohol intake of 3 or more units per day, 7) rheumatoid arthritis, 8) secondary causes of osteoporosis?

Continued on Page 2

If you have any questions, call: 800-753-2851

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Continued from Page 1

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

If you have any questions, call: 800-753-2851