



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, prempo, 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?

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



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

Horizontal lines for documentation

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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