maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Duavee

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the patient a woman? [If no, no further questions.] [Note: A woman is defined as an individual with the biological traits of a woman, regardless of the individual's gender identity or gender expression.]	Yes	No
2	Is the patient LESS THAN 75 years of age? [If no, no further questions.]	Yes	No

If you have any questions, call: 1-888-258-8250

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3	Does the patient have an intact uterus? [If no, no further questions.]	Yes	No
4	What is the diagnosis or indication? [] Treatment of vasomotor symptoms associated with menopause (VMS) (If checked, go to 5) [] Prevention of postmenopausal osteoporosis (If checked, go to 6) [] All other diagnoses/indication (If checked, no further questions)		
5	Has the patient failed OR has an intolerance to AT LEAST 2 of the following formulary estrogen/progestin products: A) Premarin tablets/cream, B) Estrace cream, C) Yuvafem, D) Prempro tablets, E) Premphase, F) Combipatch, G) estradiol tablet/patch, H) estropipate tablet, I) norethindrone-ethinyl estradiol tablets? [No further questions.]	Yes	No
6	Has the patient tried and failed raloxifene AND alendronate? [If yes, skip to question 8.]	Yes	No
7	Does the patient have a contraindication or intolerance to raloxifene AND alendronate? [If no, no further questions.]	Yes	No
8	Does the patient have osteopenia defined as a T-score between -1.0 and -2.5? [If yes, no further questions.]	Yes	No
9	Is the patient at a high risk for osteoporotic fractures? [If no, no further questions.]	Yes	No
10	Does the patient have a FRAX risk GREATER THAN or EQUAL TO 3 % for hip fracture OR GREATER THAN or EQUAL TO 20% for any major osteoporotic-related fracture? [If yes, no further questions.] [Note: FRAX = fracture risk assessment tool.]	Yes	No
11	Does the patient have AT LEAST one of the following risk factors for fracture: A) low body mass index, B) previous fragility fracture, C) parental history of hip fracture, D) glucocorticoid treatment, E) current smoking, F) alcohol intake of 3 or more units per day, G) rheumatoid arthritis, H) secondary causes of osteoporosis?	Yes	No

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

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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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