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 this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 7)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 7.]

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	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
8	Is the patient LESS THAN 75 years of age? [If no, no further questions.]	Yes	No
9	Does the patient have an intact uterus? [If no, no further questions.]	Yes	No
10	What is the diagnosis or indication? [] Treatment of vasomotor symptoms associated with menopause (VMS) (If checked, go to 11) [] Prevention of postmenopausal osteoporosis (If checked, go to 12) [] All other diagnoses/indication (If checked, no further questions)		
11	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? [If yes, skip to question 18.] [If no, no further questions.]	Yes	No
12	Has the patient tried and failed raloxifene AND alendronate?	Yes	No

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	[If yes, skip to question 14.]		
13	Does the patient have a contraindication or intolerance to raloxifene AND alendronate? [If no, no further questions.]	Yes	No
14	Does the patient have osteopenia defined as a T-score between -1.0 and -2.5? [If yes, skip to question 18.]	Yes	No
15	Is the patient at a high risk for osteoporotic fractures? [If no, no further questions.]	Yes	No
16	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, skip to question 18.] [Note: FRAX = fracture risk assessment tool.]	Yes	No
17	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? [If no, no further questions.]	Yes	No
18	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? Note: Duavee (conjugated estrogens 0.45 mg/bazedoxifene 20 mg) once daily.	Yes	No

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: 1-833-896-0656

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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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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