Prior Authorization Request Form for
estradiol **(Imvexxy)**

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	____________	Physician Name:	____________
Address:	____________	Address:	____________
	____________		____________
Sponsor ID #	____________	Phone #:	____________
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

Question	Yes	No
1. **Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Imvexxy*	☐ Yes (subject to verification) Proceed to Question **5**	☐ No Proceed to Question **2**
2. **Is the patient a postmenopausal woman with a diagnosis of moderate to severe dyspareunia due to vulvar and vaginal atrophy?**	☐ Yes Proceed to Question **3**	☐ No **STOP** **Coverage not approved**
3. **Has the patient tried and failed or has a contraindication to a low-dose vaginal estrogen preparation (e.g., Premarin vaginal cream, Estrace vaginal cream, Estring, Vagifem)?**	☐ Yes Proceed to Question **4**	☐ No **STOP** **Coverage not approved**
4. **Does the patient have any of the following: undiagnosed abnormal genital bleeding, pregnant or breastfeeding, history of breast cancer or currently has active breast cancer, OR history of thromboembolic disease or currently have thromboembolism?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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5. Has the patient had an improvement in dyspareunia symptom severity?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge.
Please sign and date:

Prescriber Signature ______________________ Date ____________

[25 July 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: