Prior Authorization Request Form for
prasterone (Intrarosa)

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:**

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 Intrarosa*	☐ Yes Proceed to question **6**	☐ No Proceed to question **2**
2. Is the patient a post-menopausal 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 a low dose vaginal estrogen preparation (for example: 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: **1) Undiagnosed abnormal genital bleeding** **2) Pregnant or breastfeeding or** **3) History of breast cancer or currently have breast cancer?**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **5**
5. Will Intrarosa be used for the shortest duration consistent with treatment goals and risks for the individual woman?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

6. Has the patient had improvement in the severity of dyspareunia symptoms?	☐ 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 _____

[31 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: