Prior Authorization Request Form for levonorgestrel and ethinyl estradiol **(Twirla)**

JOHNS HOPKINS
MEDICINE

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HEALTHCARE

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

USFHP Pharmacy Prior Authorization Form

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		
1. The following agents are available for TRICARE patients without a prior authorization: norelgestromin/ethinyl estradiol transdermal system (Xulane) and numerous other contraceptives. Please consider changing the prescription to Xulane or another formulary contraceptive.	☐ Acknowledged Proceed to question **2**	
2. Has the patient had an adverse reaction to Xulane that is not expected to occur with Twirla?	☐ Yes Proceed to Question **4**	☐ No Proceed to Question **3**
3. Has the patient tried Xulane and has an intolerance to it?	☐ Yes Proceed to Question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have a contraindication to an estrogen-containing contraceptive, for example, history of estrogen-dependent neoplasia, breast cancer, deep venous thrombosis (DVT)/pulmonary embolism (PE), etc.)?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **5**
5. Is the patient's BMI greater than 30 kg/m2? Note: Twirla is contraindicated in patients with a BMI greater than or equal to 30 kg/m2.	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to Question **6**
6. Does the provider acknowledge that patients with BMI between 25 to 30 kg/m2 have decreased contraceptive effectiveness per the FDA label?	☐ 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

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