Please note: All information below is required to process this request
Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific
For real time submission 24/7 visit www.OptumRx.com and click Health Care Professionals
OptumRx • M/S CA 106-0286 • 3515 Harbor Blvd. • Costa Mesa, CA 92626

Premarin® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
Is This Medication a New Start? ❑ Yes ❑ No	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Advanced androgen-dependent carcinoma of the prostate (for palliation only)
❑ Hypoestrogenism due to hypogonadism, castration, or primary ovarian failure
❑ Metastatic breast cancer (for palliation only)
❑ Prophylaxis of postmenopausal osteoporosis
❑ Vasomotor symptoms (moderate to severe) associated with menopause
❑ Vulvar and vaginal atrophy (moderate to severe) associated with menopause
❑ Other diagnosis: _____ ICD-9/10 Code(s): _____

Risk acknowledgment:

❑ Yes ❑ No Does the provider acknowledge the risks of using this drug in the age 65 and over population?
❑ Yes ❑ No Does the provider attest that no other drug can meet the needs of the patient?

Postmenopausal osteoporosis, prophylaxis:
Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Actonel, risedronate ❑ Alendronate ❑ Binosto ❑ Ibandronate

Vasomotor symptoms (moderate to severe) associated with menopause:
Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Fluoxetine ❑ Paroxetine extended-release (ER) ❑ Venlafaxine
❑ Paroxetine ❑ Paxil ❑ Venlafaxine ER

Vulvar and vaginal atrophy (moderate to severe) associated with menopause:

❑ Yes ❑ No Does the patient have a history of failure, contraindication, or intolerance to Premarin cream?

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.