FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Estrogens Coverage Determination Request Form (Page 1 of 2)

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:	Office Contact:	
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type(s) of Coverage Determination Requested:

❑ **Non-Formulary**- Request is for a drug not on the plan's list of covered drugs OR was previously included on the plan's list is being/was removed from this list during the plan year.

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Advanced androgen-dependent carcinoma of the prostate (for palliation only)
❑ Breast cancer in women and men with metastatic disease (for palliation only)
❑ Hypoestrogenism due to hypogonadism, castration or primary ovarian failure
❑ Prevention of postmenopausal osteoporosis
❑ Vasomotor symptoms (moderate to severe) associated with menopause
❑ Vulvar and vaginal atrophy (moderate to severe) associated with menopause
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is there documentation that the patient had an inadequate response to or inability to tolerate vaginal estrogen preparations (e.g. vaginal tablets, rings, or cream, etc.)? ❑ **Yes** ❑ **No**

Is there documentation that the risk versus benefit has been assessed for this request of a high risk medication (HRM) in an elderly patient? ❑ **Yes** ❑ **No**

Select the medication(s) the patient has a history of trial and failure, or intolerance to:

❑ Amabelz	❑ Estropipate	❑ Mimvey Lo
❑ Divigel	❑ Femring	❑ Norethindrone acetate/ethinyl estradiol
❑ Estradiol cream	❑ Fyavolv	❑ Premarin
❑ Estradiol patch	❑ Jinteli	❑ Prempro
❑ Estradiol tablet	❑ Menest	❑ Yuvafem
❑ Estradiol/norethindrone acetate	❑ Menostar	
❑ Estring	❑ Mimvey	

❑ Other drugs in the same class. Please specify: _____

❑ Other therapeutic equivalent alternatives. Please specify: _____

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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.