



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

Osphena® Coverage Determination Request Form

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

Medication Information (required)		
Medication Name: Select one of the following: <input type="checkbox"/> Request is for GENERIC <input type="checkbox"/> Request is for BRAND (unable to take the generic)	Strength:	Dosage Form:
<input type="checkbox"/> Check if request is for continuation of therapy	Directions for Use:	

Clinical Information (required)
Select the Type(s) of Coverage Determination Requested: <input type="checkbox"/> Prior Authorization- Request is for a drug that requires prior authorization under the plan.
Select the diagnosis below: <input type="checkbox"/> Treatment of moderate to severe dyspareunia, a symptom of vulvar and vaginal atrophy, due to menopause <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____

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.

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