US Family Health Plan
Prior Authorization Request Form for
estradiol **(Imvexxy**)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization approval is for 1 year. For renewal of therapy an initial prior authorization approval is required.

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 an approved PA for Imvexxy*	☐ Yes (subject to verification) Proceed to Question **5**	☐ No Proceed to Question **2**
2. Is the patient a postmenopausal 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 or has a contraindication to a low-dose vaginal estrogen preparation (e.g., 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: undiagnosed abnormal genital bleeding, pregnant or breastfeeding, history of breast cancer or currently has active breast cancer, OR history of thromboembolic disease or currently have thromboembolism?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

5. Has the patient had an improvement in dyspareunia symptom severity?	☐ 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 _____