US Family Health Plan
Prior Authorization Request Form for
prasterone (**Intrarosa**)

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 855-273-5735

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 for initial approval expires after 1 year, renewal requests approve indefinitely. For renewal of therapy an initial USFHP 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 USFHP benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for Intrarosa*	☐ Yes Proceed to question **6**	☐ No Proceed to question **2**
2. Is the patient a post-menopausal 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 a low dose vaginal estrogen preparation (for example: 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: **1) Undiagnosed abnormal genital bleeding** **2) Pregnant or breastfeeding or** **3) History of breast cancer or currently have breast cancer?**	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **5**
5. Will Intrarosa be used for the shortest duration consistent with treatment goals and risks for the individual woman?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

6. Has the patient had improvement in the severity of dyspareunia symptoms?	☐ 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 ____________