Pharmacy Prior Authorization

MERCY CARE (MEDICAID)

Premarin Vaginal Cream (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Mercy Care at **1-800-854-7614**.
When conditions are met, we will authorize the coverage of Premarin Vaginal Cream (Medicaid).

Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Premarin Vaginal Cream (conjugated estrogens cream)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Has the member had a response to treatment? Y N

   [No further questions.]

3. Has the member experienced an inadequate response, intolerable side effects, or contraindication to vaginal estradiol tablets (Vagifem)? Y N

   [If yes, then no further questions.]

4. Has the member experienced an inadequate response, intolerable side effects, or contraindication to estradiol vaginal cream 0.1 percent? Y N

   [If yes, then no further questions.]

5. Is the member 10 years of age or younger with a diagnosis of labial adhesion? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**