pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

EVISTA (raloxifene) PRIOR AUTHORIZATION FORM

To review the prior authorization guidelines and Quantity Limits for Evista (raloxifene), please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Bone Resorption Suppression Agents** and **Quantity Limits/Daily Dose Limits** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Additional information ☐Renewal request (PA# _____)	# of pages in request: _____	Prescriber name:	
Name & phone # of office contact:		Specialty:	
LTC facility contact/phone:		State license #:	NPI:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/State/Zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ☐Evista 60 mg tablet ☐raloxifene 60 mg tablet			Directions:
Quantity:	Refills:	Diagnosis:	Dx code (*required*):

For all requests, complete Section A, then complete Section B or C that is applicable to Recipient's diagnosis.

Section A: All Evista/raloxifene requests		
1. Do any of the following apply to the Recipient? *Check all that apply.* ☐history of or current blood clot in leg, lungs, or eye ☐history of or current breast cancer	☐Yes ☐No	*Submit documentation.*
2. Does the Recipient have any of the following risk factors for stroke? *Check all that apply.* ☐history of stroke or transient ischemic attack (TIA) ☐hypertension ☐atrial fibrillation ☐cigarette smoker	☐Yes ☐No	*Submit documentation.*
3. *If the Recipient has any risk factors for stroke*, was the Recipient counseled regarding the increased risk of death due to stroke while taking Evista?	☐Yes ☐No	*Submit medical record documentation that the Recipient was counseled.*
4. Is the Recipient post-menopausal or post-oophorectomy?	☐Yes ☐No	*Submit documentation.*
Section B: Evista/raloxifene for reduction in the risk of invasive breast cancer		
1. Is the Recipient at **high** risk of invasive breast cancer and Evista is being prescribed to reduce this risk?	☐Yes ☐No	*Submit documentation of level of risk and all risk factors.*
2. *If the Recipient is **NOT** at **HIGH** risk of invasive breast cancer*, does the Recipient have results of a recent bone mineral density test (BMD)?	☐Yes – *submit documentation of BMD test results* ☐No	
Section C: Evista/raloxifene for osteoporosis treatment or prevention (without risks for breast cancer)		
1. Does the Recipient have results of a recent bone mineral density test (BMD)?	☐Yes – *submit documentation of BMD test results* ☐No	
2. Based on the US-adapted World Health Organization (WHO) algorithm, does one of the following apply to the Recipient? ☐10-year probability of hip fracture ≥ 3% ☐10-year probability of major fracture related to osteoporosis ≥ 20%	☐Yes ☐No	*Submit all supporting documentation risk score*
3. Was the Recipient evaluated for other possible causes of osteoporosis, including the following laboratory tests? *Check all that apply.* ☐CBC ☐phosphorous ☐thyroid stimulating hormone (TSH) ☐creatinine ☐Vitamin D ☐albumin ☐urinary calcium excretion ☐liver enzymes/LFTs ☐ionized calcium ☐total protein ☐intact parathyroid hormone (PTH) ☐testosterone (if male)	☐Yes ☐No	*Submit results of all requested lab tests*
3. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the following oral bisphosphonates? *Check all that apply.* ☐Actonel tablet ☐Atelvia DR tablet ☐Fosamax tablet ☐risedronate tablet ☐alendronate tablet ☐Binosto tablet ☐Fosamax Plus D tab ☐risedronate DR tablet ☐alendronate oral sol'n ☐Boniva tablet ☐ibandronate tablet	☐Yes – *submit all supporting documentation of trial and failure, intolerance, or contraindications* ☐No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: