PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

OSPHENA
(ospemifene)

Status: CVS Caremark Criteria
Type: Initial Prior Authorization

POLICY

FDA-APPROVED INDICATIONS
Osphena is indicated for:
The treatment of moderate to severe dyspareunia, a symptom of vulvar and vaginal atrophy, due to menopause.
The treatment of moderate to severe vaginal dryness, a symptom of vulvar and vaginal atrophy, due to menopause.

COVERAGE CRITERIA
The requested drug will be covered with prior authorization when the following criteria are met:

- The requested drug is being prescribed for the treatment of any of the following: A) Moderate to severe dyspareunia (pain during sexual intercourse) due to menopause, B) Moderate to severe vaginal dryness due to menopause

AND

- The request is NOT for continuation of therapy

OR

- The request is for continuation of therapy
  AND
  - The patient has achieved or maintained a positive clinical response to the requested drug
  AND
  - The patient has been re-evaluated periodically to determine if treatment is still necessary

REFERENCES

1. Osphena [package insert]. Florham Park, NJ: Shionogi Inc.; January 2019.
2. Lexicomp Online, AHFS DI (Adult and Pediatric) Online, Hudson, Ohio: UpToDate, Inc.; 2022; Accessed December 6, 2022.
3. Micromedex (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at: https://www.micromedexsolutions.com. Accessed December 6, 2022.