Outpatient Medical Injectable
Prolia Authorization Request Form
Fax to 833-581-1861
(Medical Benefit Only)

Member Name:_____

Member Date of Birth:_____

Member ID (UMI): _____ ☐ Medicare ☐ Commercial*

Ordering/Attending Provider Name: _____NPI: _____

Ordering/Attending Provider Address:_____

Office Contact: _____ Phone #:_____Fax #:_____

Servicing Facility/Vendor Name: _____Facility NPI:_____

Servicing Facility/Vendor Address:_____

Requested Start Date of Service: _____ ICD10 Diagnosis Code(s): _____

☐ **Buy & Bill** ☐ **Drug Supplied by Specialty Pharmacy** *(Pharmacy Name:* _____ *NPI:* _____)

Please answer all the following clinical questions:

Please provide T-scores from most recent DEXA and date the DEXA scan was performed.

_____

Has the member tried and failed at least one bisphosphonate? If so, please list which bisphosphonate and why the member failed. _____

How long did the member take the bisphosphonate(s) listed above? _____

Does the member have any contraindications to bisphosphonate therapy? If so, what is the contraindication?

_____

Does the member have a history of osteoporotic fracture? If so, which bone did they fracture and what was the date of the fracture? _____

Was a FRAX calculator used? If so, what was the member's 10-year risk of major osteoporotic fracture and 10-year risk of hip fracture? _____

If the member is female:

1. Is the member post-menopausal? _____
2. Is the member taking an adjuvant aromatase inhibitor for breast cancer? If so, which medication? _____

****Please verify member's eligibility and benefits through the health plan****

If the member is male:

1. Is the member receiving androgen deprivation therapy for non-metastatic prostate cancer? If so, which medication is the member receiving? _____

☐ **New Start**	☐ **Continuation of Therapy** Date of last Prolia injection: _____ **Has the member had a positive clinical response to Prolia?** ☐ YES ☐ NO

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**