



**Outpatient Medical Injectable
Prolia Authorization Request Form
Fax to 833-619-5745
(Medical Benefit Only)**

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ Medicare Commercial

Requesting Physician's Name: _____ NPI Number: _____

Requesting Physician's Address: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

Facility: _____ Facility NPI Number: _____

Facility's Address: _____

Date of Service: _____ J Code (s): _____ Diagnosis Code(s): _____

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

Please answer 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? _____

If the member is male:

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

Fax this completed form to Highmark at 1-833-619-5745

Highmark Blue Cross Blue Shield of Western New York is a trade name of Highmark Western and Northeastern New York Inc., an independent licensee of the Blue Cross Blue Shield Association.

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

Please attach all pertinent clinical information

Attached: YES NO

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

Fax this completed form to Highmark at 1-833-619-5745

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