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:____

Drug Name and HCPCS Code: **Prolia (J0897)** 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? __________

If the member is male:

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

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**

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