Prolia

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756** to initiate the review process. If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4**.**

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Drug Information:

Strength/Measure _____*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un

Directions(sig) _____*Route of administration* _____

Dosing frequency _____

Site of Service Questions:

A. Indicate the site of service requested:
- ❑ *Ambulatory Surgical (POS Code 24)*
- ❑ *Off Campus Outpatient Hospital (POS Code 19)*
- ❑ *Office (POS Code 11)*
- ❑ *Home (POS Code 12)*
- ❑ *On Campus Outpatient Hospital (POS Code 22)*

B. Is the patient less than 18 years of age?
- ❑ Yes, *skip to Clinical Criteria Questions*
- ❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

Send completed form to: Priority Partners Fax: 1-866-212-4756

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ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes ❑ No

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. Is the request for continuation of therapy?
❒ Yes, *Continue to 2*
❒ No, *Continue to 3*

2. Is the patient currently receiving Prolia through samples or a manufacturer's patient assistance program?
❒ Yes, *Continue to 3*
❒ No, *Continue to 4*
❒ Unknown, *Continue to 3*

3. What is the diagnosis?
❒ Postmenopausal osteoporosis, *Continue to 9*
❒ Osteoporosis in a man, *Continue to 18*
❒ Glucocorticoid-induced osteoporosis, *Continue to 25*
❒ Breast cancer, *Continue to 33*
❒ Prostate cancer, *Continue to 34*
❒ Other, please specify. _____, *No further questions*

4. What is the diagnosis?
❒ Postmenopausal osteoporosis, *Continue to 5*
❒ Osteoporosis in a man, *Continue to 5*
❒ Glucocorticoid-induced osteoporosis, *Continue to 5*
❒ Breast cancer, *Continue to 5*
❒ Prostate cancer, *Continue to 5*
❒ Other, please specify. _____, *Continue to 5*

5. How long has the patient been receiving Prolia?

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❒ Less than 24 months, *Continue to 6*

❒ 24 months or more, *Continue to 7*

6. Has the patient experienced clinically significant adverse events during therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

7. Has the patient experienced clinical benefit to therapy (i.e., improvement or stabilization in T-score since the previous bone mass measurement)?
❒ Yes, *Continue to 8*
❒ No, *Continue to 8*

8. Has the patient experienced any adverse effects?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

9. Does the patient have a history of fragility fractures? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record. ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 10*

10. What is the patient's pre-treatment T-score? Please provide the patient's T-score prior to initiation of osteoporosis treatment. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record.
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 11*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *No further questions*

11. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the pa
Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied b
[clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent)
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*

❒ Less than 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 12*

❒ Unknown, *Continue to 12*

12. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture?
Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).

❒ _____ %, ***ACTION REQUIRED****: Submit supporting documentation, Continue to 13*

❒ Unknown, *Continue to 13*

13. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo, Bonsity], abaloparatide [Tymlos])?

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❒ Yes, *No Further Questions*
❒ No, *Continue to 14*

14. Does the patient have any indicators of very high fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores [-3 or below], increased fall risk)?
❒ Yes, *No Further Questions*
❒ No, *Continue to 15*

15. Has the patient had at least a 1-year trial of an oral bisphosphonate?
❒ Yes, *No Further Questions*
❒ No, *Continue to 16*

16. Is there a clinical reason to avoid treatment with an oral bisphosphonate?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Please indicate reason.

_____

No further questions

18. Does the patient have a history of an osteoporotic vertebral or hip fracture? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *No Further Questions*
❒ No, *Continue to 19*

19. What is the patient's pre-treatment T-score? Please provide the patient's T-score prior to initiation of osteoporosis treatment. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record.
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 22*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 20*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*
❒ Unknown, *No further questions*

20. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 22*
❒ Less than 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 21*
❒ Unknown, *Continue to 21*

21. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).

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❒ _____ % ***ACTION REQUIRED****: Submit supporting documentation, Continue to 22*

❒ Unknown, *Continue to 22*

22. Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate?
❒ Yes, *No Further Questions*
❒ No, *Continue to 23*

23. Is there a clinical reason to avoid treatment with a bisphosphonate?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Please indicate reason.

_____

No further questions

25. Is the patient currently receiving or will be initiating glucocorticoid therapy at an equivalent prednisone dose of greater than or equal to 2.5 mg/day for 3 months or more?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Does the patient have a history of a fragility fracture? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s). ***ACTION REQUIRED***: Submit supporting documentation
❒ Yes, *Continue to 30*
❒ No, *Continue to 27*

27. What is the patient's pre-treatment T-score? Please provide the patient's T-score prior to initiation of osteoporosis treatment. ***ACTION REQUIRED***: Attach supporting chart note(s) or medical record.
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 30*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 28*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, No further questions*

❒ Unknown, *No further questions*

28. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 30*

❒ Less than 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 29*

❒ Unknown, *Continue to 29*

29. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s).

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❒ _____ % ***ACTION REQUIRED****: Submit supporting documentation, Continue to 30*

❒ Unknown, *Continue to 30*

30. Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate?
❒ Yes, *No Further Questions*
❒ No, *Continue to 31*

31. Is there a clinical reason to avoid treatment with a bisphosphonate?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

32. Please indicate reason.

_____

No further questions

33. Is the patient receiving adjuvant aromatase inhibition therapy for breast cancer?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

34. Is the patient receiving androgen deprivation therapy for prostate cancer?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by Priority Partners.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

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