# 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*_____

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

**Site of Service Questions:**

A. Indicate the site of service requested:
- ❑ On Campus Outpatient Hospital (22)
- ❑ Off Campus Outpatient Hospital (19)
- ❑ Home (12), *skip to Criteria Questions*
- ❑ Office (11), *skip to Criteria Questions*
- ❑ Ambulatory Surgical Center (24), *skip to Criteria Questions*

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?
***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:**

1. What is the diagnosis?
   - ❑ Postmenopausal osteoporosis
   - ❑ Glucocorticoid-induced osteoporosis
   - ❑ Osteoporosis in a man
   - ❑ Breast cancer
   - ❑ Prostate cancer
   - ❑ Other _____

2. What is the ICD-10 code? _____

3. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to Section A (if applicable).*

4. Is the patient currently receiving Prolia through samples or a manufacturer's patient assistance program?
*If Yes or Unknown, skip to Section A (if applicable).* ❑ Yes ❑ No ❑ Unknown

5. Has the patient experienced clinical benefit as evidenced by a bone mass measurement showing an improvement or stabilization in T-score compared with the previous bone mass measurement? ❑ Yes ❑ No *If No, skip to #7*

6. Has the patient experienced any adverse effects? ❑ Yes ❑ No *No further questions*

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7. How long has the patient been receiving Prolia? _____months

8. Has the patient experienced a clinical benefit from therapy as evidenced by no adverse events during therapy (i.e., no clinically significant adverse reaction to the requested drug, no new fracture seen on radiography)?
❑ Yes ❑ No *No further questions*

***Complete the following section based on the patient's diagnosis, if applicable.***

Section A: All Osteoporosis Requests

9. What is the patient's pretreatment T-score? *Please provide the patient's T-score prior to initiation of osteoporosis treatment.* ***ACTION REQUIRED: Attach supporting chart note(s).*** **_____** ❑ Unknown
*If* -2.5 or below (e.g., -2.6, -2.7, -3), *skip to #12*

10. What is the patient's pretreatment FRAX score for any major fracture? (See Appendix). *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment.* ***ACTION REQUIRED: Attach supporting chart note(s).***
_____ % ❑ Unknown *If greater than or equal to 20%, skip to #12.*

11. What is the patient's pre-treatment FRAX score for hip fracture? (See Appendix). *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment.* ***ACTION REQUIRED: Attach supporting chart note(s).***
**_____**% ❑ Unknown

12. Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate?
*If Yes, skip to diagnosis section.* ❑ Yes ❑ No

13. Is there a clinical reason to avoid treatment with a bisphosphonate? ❑ Yes ❑ No
*If Yes, please indicate:* _____

Section B: Postmenopausal Osteoporosis or Glucocorticoid-Induced Osteoporosis

14. Does the patient have a history of fragility fractures? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and no further questions.*** ❑ Yes ❑ No

15. *If the diagnosis is postmenopausal osteoporosis,* 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])?
*If Yes, no further questions.* ❑ Yes ❑ No

16. 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

17. *If diagnosis is glucocorticoid-induced osteoporosis,* is the patient currently receiving or will be initiating glucocorticoid therapy at an equivalent prednisone dose of ≥ 2.5 mg/day for ≥ 3 months? ❑ Yes ❑ No

Section C: Osteoporosis in Men

18. Does the patient have a history of an osteoporotic vertebral or hip fracture? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

Section D: Breast Cancer

19. Is the patient receiving adjuvant endocrine therapy for breast cancer? ❑ Yes ❑ No

Section E: Prostate Cancer

20. Is the patient receiving androgen deprivation therapy for prostate cancer? ❑ Yes ❑ No

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Appendix:

- *Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp
- 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.

***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 oruthorized Signature** **Date (mm/dd/yy)**

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