OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Prolia® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Bone loss in men receiving androgen deprivation therapy for non-metastatic prostate cancer
- ❑ Bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer
- ❑ Glucocorticoid-induced osteoporosis at high risk for fracture
- ❑ Increase bone mass in men at high risk for fracture with osteoporosis or osteopenia
- ❑ Postmenopausal women with osteoporosis or osteopenia at high risk of fracture
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the patient has history of fracture(s) resulting from minimal trauma including the following:

- ❑ Fracture of the distal radius
- ❑ Fracture of the hip
- ❑ Fracture of the pelvis
- ❑ Fracture of the proximal humerus
- ❑ Vertebral compression fracture

For bone loss in men receiving androgen deprivation therapy for non-metastatic prostate cancer, also answer the following:

Does the patient have non-metastatic prostate cancer? ❑ **Yes** ❑ **No**

Select if the patient is undergoing androgen deprivation therapy with the following:

- ❑ Luteinizing hormone-releasing hormone (LHRH)/gonadotropin releasing hormone (GnRH) agonist (e.g., Eligard/Lupron [leuprolide], Trelstar [triptorelin], Vantas [histrelin], and Zoladex [goserelin])
- ❑ Bilateral orchiectomy (e.g., surgical castration)

Document the bone mineral density (BMD) scan T-score: _____ (specify if negative)

Reauthorization:

Select if the patient is undergoing androgen deprivation therapy with the following:

- ❑ Luteinizing hormone-releasing hormone (LHRH)/gonadotropin releasing hormone (GnRH) agonist (e.g., Eligard/Lupron [leuprolide], Trelstar [triptorelin], Vantas [histrelin], and Zoladex [goserelin])
- ❑ Bilateral orchiectomy (e.g., surgical castration)

Is there evidence of metastases? ❑ **Yes** ❑ **No**

Is the patient benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, or improved biochemical markers, etc.)? ❑ **Yes** ❑ **No**

Prolia® Prior Authorization Request Form (Page 2 of 2)

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For bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer, also answer the following:

Does the patient have breast cancer? ❑ **Yes** ❑ **No**

Is the patient receiving adjuvant aromatase inhibitor therapy (e.g., Arimidex [anastrozole], Aromasin [exemestane], Femara [letrozole])? ❑ **Yes** ❑ **No**

Document the bone mineral density (BMD) scan T-score: _____ (specify if negative)

Has the patient had trial and failure, contraindication, or intolerance to one bisphosphonate therapy (e.g., alendronate)? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient receiving adjuvant aromatase inhibitor therapy (e.g., Arimidex [anastrozole], Aromasin [exemestane], Femara [letrozole])? ❑ **Yes** ❑ **No**

Is the patient benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, or improved biochemical markers, etc.)? ❑ **Yes** ❑ **No**

For glucocorticoid-induced osteoporosis, also answer the following:

Is the patient initiating or continuing on greater than or equal to 7.5 mg/day of prednisone (or its equivalent) and is expected to remain on glucocorticoid therapy for at least 6 months? ❑ **Yes** ❑ **No**

Document the bone mineral density (BMD) T-score from the lumbar spine, femoral neck, total hip, or radius (one-third radius site):

T-Score: _____ (specify if negative)

Select if the patient has the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities:

❑ Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions
❑ Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions

Has the patient had trial and failure, intolerance, or contraindication to one bisphosphonate therapy (e.g., alendronate)? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, or improved biochemical markers, etc.) without significant adverse effects? ❑ **Yes** ❑ **No**

For increase bone mass in men at high risk for fracture or postmenopausal women with osteoporosis or osteopenia at high risk of fracture, also answer the following:

Document the bone mineral density (BMD) T-score from the lumbar spine, femoral neck, total hip, or radius (one-third radius site):

T-Score: _____ (specify if negative)

Select if the patient has the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities:

❑ Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions
❑ Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions

Has the patient had trial and failure, intolerance, or contraindication to one bisphosphonate therapy (e.g., alendronate)? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, or improved biochemical markers, etc.) without significant adverse effects? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per YEAR? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.