Prior Authorization Request Form
Fax Back To: 1-800-853-3844
Phone: 1-800-711-4555
5 AM – 7 PM PT M-F
or visit www.OptumRx.com and click Health Care Professionals for online real-time submission 24/7

Prior Authorization Request Form

Member Information

Member's Name:

Insurance ID #: Date of Birth:

Address: Apartment #:

City: State: Zip:

Phone Number: Alternate Phone: Sex: ☐ Male ☐ Female

Provider Information

Provider's Name: NPI#:

Address: City: State: Zip:

Suite Number: Building Number:

Phone Number: Fax number:

Provider's Specialty:

Medication Information*

Medication Name: Strength: ICD-10 Code:

Directions for use: Diagnosis:

Is this medication a **New Start**? ☐ Yes ☐ No

If **NO** Please provide the following: Initiation Date: Date of Last Dose:

***This information will only be used for coverage determination requests administered by OptumRx.**

Administration Instructions

Medication Administered: Self-Administered ☐ Home Health ☐ LTC ☐ Physician's Office ☐

Is the physician supplying the medication? ☐ Yes ☐ No

***Please note this request may be denied unless a complete supporting statement is received. Please complete form and fax to OptumRx 1-800-853-3844.**

For urgent or expedited requests please call 1-800-711-4555.

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OptumRx Specialty Prior Authorization (continued)

Document the patient's diagnosis: _____ ICD-9 / ICD-10 Code: _____

Document the lowest T-score recorded for the patient on a Bone Mineral Density Scan (BMD):

T-score: _____ Anatomical location: _____ Date: _____

Does the patient have a history of trial, failure, contraindication or intolerance to **ANY** of the following: ***(Select all that applies)***

- ☐ Selected estrogen-receptor modulator (SERM)
- ☐ Actonel with calcium (risedronate sodium with calcium)
- ☐ Boniva (ibandronate sodium) oral tablets
- ☐ Fosamax + D (alendronate sodium and cholecalciferol)
- ☐ Other Bisphosphonates ***Specify*** _____
- ☐ Actonel (risedronate sodium)
- ☐ Evista (raloxifene)
- ☐ Reclast IV
- ☐ Miacalcin (calcitonin-salmon) Nasal Spray
- ☐ Fosamax (alendronate sodium)
- ☐ Boniva (ibandronate sodium) IV
- ☐ Miacalcin (calcitonin-salmon) INJ

Does the patient have a history of compression fractures resulting from minimal trauma? ☐ Yes ☐ No

Document which applies to the patient:

- ☐ Vertebral compression fractures Date: _____ Location of fracture: _____
- ☐ Fractures of the hip Date: _____
- ☐ Fractures of the distal radius Date: _____

For ESRD-related conditions or uses

Is the prescriber (i.e., nephrologist, nurse practitioner, or physician assistant) receiving a monthly capitation payment to manage ESRD patient's care? ☐ Yes ☐ No

Is the medication prescribed to be used for an ESRD-Related condition (i.e., drug is used to prevent/treat bone disease secondary to dialysis)? ☐ Yes ☐ No

Treatment of Osteoporosis

Which Diagnosis applies to the patient: ☐ Osteoporosis ☐ Postmenopausal osteoporosis ☐ Other _____

☐ Men with Primary or hypogonadal osteoporosis at high risk for fracture

For Reclast or Prolia Request:

Will this be used for the prevention of postmenopausal osteoporosis? ☐ Yes ☐ No

Document which applies to the patient: ***[Based on the WHO Fracture Risk Algorithm (FRAX)]***

- ☐ A 10-year probability of a hip fracture greater than or equal to 3%
- ☐ A 10-year probability of a major osteoporosis-related fracture greater than or equal to 20%

For Forteo Request:

Has the patient ever used this medication? ☐ Yes ☐ No If **YES:** Provide the total duration of therapy to current date: _____

Treatment of Glucocorticoid-induced Osteoporosis

For Reclast Request:

Will this be used for prevention of glucocorticoid-induced osteoporosis in patients who are initiating or continuing on greater or equal to 7.5mg/day of oral prednisone (or equivalent) for at least 12 months? ☐ Yes ☐ No

For Forteo Request:

Does the patient have a history of taking prednisone or its equivalent at a dose greater than or equal to 5mg/day for greater than or equal to 3 months? ☐ Yes ☐ No **Document medication, dose & duration:** _____

Has the patient ever used this medication? ☐ Yes ☐ No If **YES:** Provide the total duration of therapy to current date: _____

Treatment of Moderate to severe Hypercalcemia

Document Corrected total serum calcium: _____ Date drawn: _____

Reauthorization: Has the corrected total serum calcium concentration failed to normalize or remain normal after the initial treatment?

☐ Yes ☐ No **Document Corrected total serum calcium:** _____ **Date drawn:** _____

For treatment of bone loss with nonmetastatic prostate cancer *(For Male members only)*

Is the patient undergoing androgen deprivation therapy with **ANY** of the following? ☐ Yes ☐ No ***(Select all that applies to patient)***

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

Reauthorization: Is there evidence of metastases? ☐ Yes ☐ No

For treatment of bone loss with breast cancer *(For Female members only)*

Is the patient receiving adjuvant aromatase inhibitor therapy [e.g., Arimidex (anastrazole), Aromasin (exemestane), Femara (letrozole)]?

☐ Yes ☐ No

*****If you have any questions regarding your patient's plan drug limits you may call us at: 1-800-711-4555.

OptumRx Specialty Prior Authorization (continued)

Treatment of Osteolytic or Metastic bone lesions

Does the patient have Solid Tumor (e.g., breast cancer, prostate cancer), stage III Multiple Myeloma **or** active (symptomatic) multiple myeloma? ☐ Yes ☐ No If **YES, *Specify*** _____

Does the patient have one or more predominately lytic, metastic bone lesions? ☐ Yes ☐ No

Document serum creatinine level: _____ mg/dL Drawn Date: _____

Treatment of Paget's disease

Is the serum alkaline phosphatase elevated greater than or equal to 2 times the upper limit of the normal reference range? ☐ Yes ☐ No

Is the patient experiencing symptoms associated with Paget's disease (e.g., bone pain at a pagetic site, radicular or arthritic pain caused by bone involvement that affects nerve roots or joints, neurological symptoms arising in the setting of active pagetic bone impacting on neural tissues)? ☐ Yes ☐ No

Is the patient at risk for complications (e.g., patients with active Paget's disease at skeletal sites such as the skull, spine, weight-bearing long bones, and bones adjacent to major joints such as hip or knee)? ☐ Yes ☐ No

Reauthorization

Does the patient continues to experience symptoms associated with Paget's disease(e.g., bone pain and/or deformity, neurologic disorders, elevated cardiac output, and other vascular disorders, high output heart failure)? ☐ Yes ☐ No

RECLAST Therapy: Has the serum alkaline phosphatase failed to normalize after the previous therapy? ☐ Yes ☐ No

MIACALCIN Therapy: Is the serum alkaline phosphatase and/or urinary hydroxyproline levels elevated based on the normal reference ranges provided by the physician's laboratory? ☐ Yes ☐ No

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