Please note: All information below is required to process this request
Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific
For real time submission 24/7 visit www.OptumRx.com and click Health Care Professionals
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Aredia® 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**		
Is the physician supplying the medication? ❑ **Yes** ❑ **No**		

Clinical Information (required)

Document the patient's diagnosis: _____ 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 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**

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

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❑ **Treatment of Osteoporosis**

Which diagnosis applies to the patient:

- ❑ Osteoporosis
- ❑ Postmenopausal osteoporosis
- ❑ Men with Primary or hypogonadal osteoporosis at high risk for fracture
- ❑ Other diagnosis (please specify)_____

For Reclast 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%

❑ **Treatment of Glucocorticoid-induced Osteoporosis**

Is the patient initiating or continuing on dose greater or equal to 7.5mg/day of oral prednisone (or equivalent) for at least 12 months?

❑ **Yes** ❑ **No**

❑ **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: _____

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-853-3844.