PriorityHealth

Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Prolia® (denosumab)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product and Billing Information

☐ New request ☐ Continuation request

Drug product: ☐ Prolia 60 mg/mL syringe

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Date of next dose (if applicable): _____

Dose:_____ **Dose Frequency**:_____

Place of administration:

☐ Physician's office

☐ Outpatient infusion

Facility: _____ NPI:_____ Fax:_____

☐ Home infusion

Facility: _____ NPI:_____ Fax:_____

Billing:

☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy:_____ NPI:_____ Fax:_____

ICD-10 Diagnosis code(s): _____

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 12/2018

Last reviewed 01/2019

Precertification Requirements

Before this drug is covered, the patient must meet one of the following requirements (provide supporting documentation):

Initiation Criteria

1. Must have a diagnosis of osteoporosis (males or postmenopausal females with T-score of ≤-2.5 or T-score > -2.5 with fragility fracture) , and
   - Must first try one formulary oral bisphosphonate (e.g. alendronate, ibandronate) AND zoledronic acid (generic Reclast) for a period of at least 24 months combined with failure to improve bone mineral density or experienced a fracture on therapy.

2. Must have prostate cancer and used to increase bone mass in a male taking androgen deprivation therapy or have breast cancer and used to increase bone mass in a female taking adjuvant aromatase inhibitor therapy, and
   - Must first try one formulary oral bisphosphonate (e.g. alendronate, ibandronate) OR zoledronic acid (generic Reclast) for a period of at least 24 months with failure to improve bone mineral density or experienced a fracture on therapy.

Prolia may be approved for 24 months of therapy. For continuation of previously authorized osteoporosis treatment, patients must meet continuation criteria.

Continuation Criteria

1. Must continue to meet initiation criteria 1 OR 2 above

AND

2. Have an ongoing need for treatment as evidenced by ONE of the following:
   - T-score of ≤-2.5
   - Be at high risk for fracture such as: Long-term corticosteroid use (7.5 mg prednisone (or equivalent) or higher for 3 months or longer), untreated hypogonadism, spontaneous or surgical premature menopause at less than age 45, hyperparathyroidism, hyperthyroidism, chronic liver disease, patient has epilepsy or is taking anticonvulsant therapy, or a documented fragility fracture.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

New Request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Male with osteoporosis;

T-score _____ Date_____

Fracture history_____ Date_____

☐ Postmenopausal osteoporosis

T-score _____ Date_____

Fracture history_____ Date_____

☐ Increase bone mass in a male at high risk of fracture

What androgen deprivation therapy is the patient receiving?_____

☐ Increase bone mass in a female at high risk of fracture

What aromatase inhibitor therapy is the patient receiving?_____

☐ Other – the patient's condition is: _____

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Last reviewed 01/2019

B. The patient has tried the following medications for osteoporosis treatment:

Drug	Dose	Dates of Use	Therapy Outcome

Continuation of Previously Authorized Approval
Priority Health Precertification Documentation

A. The patient's current T-score is_____ Date_____

B. The patient is at high risk for fracture for the following medically supported reasons:

- ☐ Long-term corticosteroid use (7.5 mg prednisone (or equivalent) or higher for 3 months or longer)
- ☐ Untreated hypogonadism
- ☐ Spontaneous or surgical premature menopause at less than age 45
- ☐ Hyperparathyroidism
- ☐ Hyperthyroidism
- ☐ Chronic liver disease
- ☐ Epilepsy or is taking anticonvulsant therapy
- ☐ Documented fragility fracture.

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