FUTURE SCRIPTS Secure

Please complete ALL information below and fax your request to 1-888-671-5285

Prolia® Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Osteopenia

❑ Osteoporosis

❑ Other diagnosis: _____ ICD-10 Code(s): _____

For osteopenia, answer the following:

Is the patient using Prolia for the treatment of osteopenia (T-score less than negative 1.0 but greater than negative 2.5)? ❑ **Yes** ❑ **No**

For females: Is the patient receiving adjuvant aromatase inhibitor therapy for breast cancer? ❑ **Yes** ❑ **No**

For males: Is the patient receiving androgen deprivation therapy for non-metastatic prostate cancer? ❑ **Yes** ❑ **No**

For osteoporosis, answer the following:

Select if the following applies to the patient:

❑ T-score less than or equal to negative 2.5

❑ History of osteoporotic fracture (e.g., vertebral, hip, non-vertebral)

❑ Multiple risk factors for fracture

Has the patient had an inadequate response or inability to tolerate at least one other osteoporosis medicine (e.g., oral bisphosphonates, calcitonin, estrogens, selective estrogen receptor modulator [SERMs])? ❑ **Yes** ❑ **No**

Does the patient have a severely deteriorated condition indicating that the osteoporosis is so significant that a trial of oral bisphosphonates is not medically warranted? ❑ **Yes** ❑ **No**

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.