

PRIOR AUTHORIZATION REQUEST FORM PROLIA®, XGEVA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

DOB:	Date:		Member Name:		ID#:	ID#:			
Height/Weight: Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested: □ Prolia® (denosumab), □ XGEVA® (denosumab) Dosing/Frequency: □	DOB:		Gender:		Phys	Physician:			
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preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria. Product being requested: □ Prolia* (denosumab), □ XGEVA* (denosumab) Dosing/Frequency: If the request is for reauthorization, proceed to reauthorization section Questions Yes No Comments/Notes PROLIA* FOR OSTEOPROSIS Please provide documentation density (BMD) T-score of ≤ -2.5 by DEXA scan? Please provide documentation density (BMD) T-score of ≤ -2.5 by DEXA scan? Please provide documentation bisphosphonate? PROLIA* FOR BONE LOSS SECONDARY TO AROMATASE INHIBITORS Has the member been diagnosed with breast cancer and is currently taking an aromatase inhibitor? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan? Please provide documentation density (BMD) T-score of < -1.0 by DEXA scan?	Hei	ght/Weight:			HCPCS Code:				
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Confidentiality Notice

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2.	Does the member have a FRAX score of 10 year probability of hip fracture >3% or a 10 year probability of major osteoporosis-related fracture of >20%?			Please provide documentation				
3.	Has the member had a 24-month trial and failure to a			Please provide documentation				
	bisphosphonate?							
XGEVA®								
1.	Has the member been diagnosed with giant cell tumor of			Please provide documentation				
	bone that is unresectable or where surgical resection is likely to result in severe morbidity?							
2.	Does the member have a diagnosis of metastatic bone			Please provide documentation				
	disease from solid tumor and has had a trial and failure to a			·				
	bisphosphonate?							
3.	Has the member been diagnosed with hypercalcemia of			Please provide documentation				
	malignancy refractory to bisphosphonate therapy?							
4.	Has the member had a trial and failure of an intravenous			Please provide documentation				
	bisphosphonate, unless contraindicated?							
	REAUTHORIZATION							
1.	Is the request for reauthorization of therapy?							
2.	Has the member's therapy been re-evaluated within the past							
	12 months?							
3.	Has the therapy shown to be effective with an improvement or stabilization in condition?			Please provide documentation				
4.	Does the member have a continued medical need for the therapy?			Please provide documentation				
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.								
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Additional information:								
Dhysician's Cignoture								
Physician's Signature:								
1								

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Policy PHARM- M006 Origination Date: 08/07/2017 Reviewed/Revised Date: 06/21/2022 Next Review Date: 06/21/2023 Current Effective Date: 07/01/2022

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