

HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

PROLIA®, XGEVA®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 801-213-1547.

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

If you have medical pharmacy prior authorization questions, please call for assistance: 833-981-0212

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

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:	HCPCS Code:	

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: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
PROLIA® FOR OSTEOPOROSIS			
1. Has the member been diagnosed with osteoporosis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does the member have a documented baseline bone mineral density (BMD) T-score of ≤ -2.5 by DEXA scan?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member had a 24-month trial and failure to a bisphosphonate?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
PROLIA® FOR BONE LOSS SECONDARY TO AROMATASE INHIBITORS			
1. Has the member been diagnosed with breast cancer and is currently taking an aromatase inhibitor?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does the member have a documented baseline bone mineral density (BMD) T-score of < -1.0 by DEXA scan?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member had a 24-month trial and failure with a bisphosphonate?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
PROLIA® FOR HORMONE- SENSITIVE PROSTATE CANCER			
1. Has the member been diagnosed with Hormone-Sensitive Prostate Cancer and currently taking androgen deprivation therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
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 $>20\%$?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

3. Has the member had a 24-month trial and failure to a bisphosphonate?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
XGEVA®			
1. Has the member been diagnosed with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
2. Does the member have a diagnosis of metastatic bone disease from solid tumor and has had a trial and failure to a bisphosphonate?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
3. Has the member been diagnosed with hypercalcemia of malignancy refractory to bisphosphonate therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Has the member had a trial and failure of an intravenous bisphosphonate, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with an improvement or stabilization in condition?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does the member have a continued medical need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	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.			
Additional information:			
Physician's Signature:			

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

Policy: PHARM-CUIP-M006
 Origination Date: 07/01/2024
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 07/01/2024

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