

Today's date _____

Date medication needed _____

Prior Authorization Form Prolia®/Xgeva®



ONLY COMPLETED REQUESTS WILL BE REVIEWED

Prolia® Xgeva®

Check one: New start Continued treatment

Patient information (please print)

Patient name _____

Address _____

City, state, ZIP _____

Patient telephone # _____

Patient ID # _____

Date of birth _____ Height _____ Weight _____

Physician information (please print)

Prescribing physician _____

Office address _____

City, state, ZIP _____

Office contact _____

Office telephone # _____

Fax # _____ NPI _____

Upon approval, delivery is available by completing the section below.

N/A – No delivery requested (authorization only – physician will use office supply)

Delivery requested (indicate where medication should be delivered: Physician's office Patient's home)

****A copy of the prescription must accompany the medication request for delivery.****

1. **Physician specialty (required; specify all specialties)** _____

2. **Diagnosis for drug requested (must include ICD-9):**

733._____ Osteoporosis Other (specify ICD-9) _____

3. **Patient medical information:**

a. Does the patient have a history of osteoporotic fracture (e.g., vertebral, hip, nonvertebral)? Yes No

b. Does the patient have multiple risk factors for fracture (e.g., endocrine disorders, gastrointestinal disorders, use of medications associated with low bone mass or bone loss, such as corticosteroids)? Yes No

c. Does the patient have a T-score less than or equal to -2.5 for osteoporosis? Yes No

d. Does the patient have documented bone metastases from a solid tumor? Yes No

e. The individual has or has had one of the following (check all that apply):

- documented failed trial of or intolerance to at least one other osteoporosis medicine (e.g., oral bisphosphonates, calcitonin, estrogens) due to side effects;
- documented inadequate response from at least one other available osteoporosis medicine (e.g., oral bisphosphonates, calcitonin, estrogens) after a trial of 12 months;
- severely deteriorated condition such that the osteoporosis is so significant that a trial of oral bisphosphonates is not medically warranted.

4. **Patient history (please list any previous or current therapies related to the diagnosis):**

Drug name	Dates	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. **Prescription information:** Quantity _____ Refill x _____ month(s)

Instructions (include dose) _____ every _____ day(s)/ week(s)/ month(s)

Physician's signature _____

Fax completed form to 215-761-9165. Your office will receive a response by fax within two business days.