



Today's date: _____

Intended date of injection: _____

Prior Authorization Form – Prolia® / Xgeva®

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Select one: Prolia® Xgeva® Check one: New start Continued treatment

Patient information (please print)

Physician information (please print)

Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of Birth	Fax #	NPI

- No delivery requested; physician will use office supply. Authorization only.
- Delivery requested to the physician's office.

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

1) **Diagnosis for drug requested (must include ICD-10):** _____

2) **Patient medical information**

- a. T-score (required; fax DEXA results and date of most recent measurement) _____
- b. Is the patient post-menopausal? Yes No
- c. Does the patient have a history of osteoporotic non-collision fracture (e.g., vertebral, hip, nonvertebral)? Yes No
- d. 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
- e. Does the patient have documented bone metastases from a solid tumor? Yes No
- f. Does the patient have a history of any of the following? (check all that apply) Yes No
 - Documented history of failure, contraindication, or intolerance due to side effects to at least one other osteoporosis medicine (e.g., oral bisphosphonates, calcitonin, estrogens);
 - Documented inadequate response to at least one other osteoporosis medicine (e.g., oral bisphosphonates; estrogens) after a 12-month trial;
 - Severely deteriorated condition such that the osteoporosis is so significant that a trial of oral bisphosphonates is not medically warranted;
 - Receiving adjuvant aromatase inhibitor therapy for **breast cancer** with _____ (list drug);
 - Receiving androgen deprivation therapy for **nonmetastatic prostate cancer** with _____ (list drug);
 - Giant cell tumor of the bone, which is either unresectable or in a location where surgical resection is likely to result in severe morbidity;
 - Documented renal insufficiency.

3) **Prescription Information**

Quantity _____ Refill x _____ month(s)

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

Physician's Signature: _____

Please fax this completed form to 215-761-9580.