PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Prolia® Prior Authorization Request Form (Page 1 of 3)

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

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Bone loss in men receiving androgen deprivation therapy for nonmetastatic prostate cancer
❑ Bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer
❑ Increase bone mass in men at high risk for fracture
❑ Postmenopausal women with osteoporosis at high risk of fracture
❑ Prevention of postmenopausal osteoporosis
❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical information:

Document the bone mineral density (BMD) scan T-score: _____

For bone loss in men receiving androgen deprivation therapy for nonmetastatic prostate cancer, also answer the following:

Select if the patient is undergoing androgen deprivation therapy with the following:

❑ Luteinizing hormone-releasing hormone (LHRH)/gonadotropin releasing hormone (GnRH) agonist [e.g., Eligard/Lupron (leuprolide), Trelstar (triptorelin), Vantas (histrelin), and Zoladex (goserelin)]
❑ Bilateral orchiectomy (e.g., surgical castration)

Does the patient have history of fractures resulting from minimal trauma including one of the following: vertebral compression fracture, fracture of the hip, fracture of the distal radius? ❑ **Yes** ❑ **No**

Reauthorization:

Select if the patient is undergoing androgen deprivation therapy with the following:

❑ Luteinizing hormone-releasing hormone (LHRH)/gonadotropin releasing hormone (GnRH) agonist [e.g., Eligard/Lupron (leuprolide), Trelstar (triptorelin), Vantas (histrelin), and Zoladex (goserelin)]
❑ Bilateral orchiectomy (e.g., surgical castration)

Is there evidence of metastases? ❑ **Yes** ❑ **No**

Is the patient benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, or improved biochemical markers, etc.)? ❑ **Yes** ❑ **No**

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For bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer, also answer the following:

Is the patient receiving aromatase inhibitor therapy [e.g., Arimidex (anastrozole), Aromasin (exemestane), Femara (letrozole)]? ❑ **Yes** ❑ **No**

Does the patient have history of fractures resulting from minimal trauma including one of the following: vertebral compression fracture, fracture of the hip, fracture of the distal radius? ❑ **Yes** ❑ **No**

Select if the patient has a documented trial and therapeutic failure with a bisphosphonate as defined by the presence of the following:
- ❑ New fractures in complaint patient on therapy for at least 6 months
- ❑ Failure to produce a clinical significant change in biochemical marker(s) of bone turnover
- ❑ Significant loss of bone mineral density on follow-up scans after 12 to 24 months of therapy

Does the patient have documented contraindication or intolerance to bisphosphonate therapy? ❑ **Yes** ❑ **No**

Is the patient able to comply with appropriate administration recommendations for oral or injectable bisphosphonate therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient receiving aromatase inhibitor therapy [e.g., Arimidex (anastrozole), Aromasin (exemestane), Femara (letrozole)]? ❑ **Yes** ❑ **No**

Is the patient benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, or improved biochemical markers, etc.)? ❑ **Yes** ❑ **No**

For increase bone mass in men at high risk for fracture or postmenopausal women with osteoporosis at high risk of fracture, also answer the following:

Does the patient have history of fractures resulting from minimal trauma including one of the following: vertebral compression fracture, fracture of the hip, fracture of the distal radius? ❑ **Yes** ❑ **No**

Select if the patient has a documented trial and therapeutic failure with a bisphosphonate as defined by the presence of the following:
- ❑ New fractures in complaint patient on therapy for at least 6 months
- ❑ Failure to produce a clinical significant change in biochemical marker(s) of bone turnover
- ❑ Significant loss of bone mineral density on follow-up scans after 12 to 24 months of therapy

Does the patient have documented contraindication or intolerance to bisphosphonate therapy? ❑ **Yes** ❑ **No**

Is the patient able to comply with appropriate administration recommendations for oral or injectable bisphosphonate therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, or improved biochemical markers, etc.)? ❑ **Yes** ❑ **No**

For prevention of postmenopausal osteoporosis, also answer the following:

Select if the patient has a documented trial and therapeutic failure with a bisphosphonate as defined by the presence of the following:
- ❑ New fractures in complaint patient on therapy for at least 6 months
- ❑ Failure to produce a clinical significant change in biochemical marker(s) of bone turnover
- ❑ Significant loss of bone mineral density on follow-up scans after 12 to 24 months of therapy

Does the patient have documented contraindication or intolerance to bisphosphonate therapy? ❑ **Yes** ❑ **No**

Is the patient able to comply with appropriate administration recommendations for oral or injectable bisphosphonate therapy? ❑ **Yes** ❑ **No**

Reauthorization:

Is the patient benefiting from therapy (e.g., improved or stabilized BMD, no new fractures, or improved biochemical markers, etc.)? ❑ **Yes** ❑ **No**

Quantity Limit Requests:

What is the quantity requested per YEAR? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

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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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	