Prolia

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Prolia SGM – 08/2018.

Criteria Questions:

1. What is the diagnosis?
   - ❑ Postmenopausal osteoporosis
   - ❑ Osteoporosis in a male patient
   - ❑ Breast cancer
   - ❑ Prostate cancer
   - ❑ Glucocorticoid-induced osteoporosis
   - ❑ Other _____

2. What is the ICD-10 code? _____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Postmenopausal Osteoporosis, Osteoporosis in a Male Patient, Glucocorticoid-Induced Osteoporosis

3. ***If diagnosis is osteoporosis in a male patient,*** does the patient have a history of an osteoporotic vertebral or hip fracture?
   - ❑ Yes *If Yes, no further questions*
   - ❑ No *If No, skip to #10*
   - ❑ Not applicable, patient is a female with postmenopausal osteoporosis

4. ***If diagnosis is Glucocorticoid-induced osteoporosis,*** is the patient currently receiving or will be initiating glucocorticoid therapy? *If Yes, skip to #8* ❑ Yes ❑ No ❑ Not applicable

5. Does the patient have a history of fragility fractures? *If Yes, no further questions* ❑ Yes ❑ No

6. Does the patient have any indicators of higher fracture risk? ❑ Yes ❑ No
   If Yes, indicate the higher fracture risk indicator: _____

7. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (i.e., zoledronic acid [Reclast], teriparatide [Forteo])? *If Yes, skip to #10* ❑ Yes ❑ No

8. Has the patient had at least a 1-year trial of an oral bisphosphonate? ❑ Yes ❑ No
   If Yes, please indicate and skip to #10: _____

9. Is there a clinical reason to avoid treatment with an oral bisphosphonate?
   - ❑ Esophageal abnormality that delays emptying such as stricture or achalasia
   - ❑ Active upper gastrointestinal problem (eg, dysphagia, erosive esophagitis)
   - ❑ Inability to stand or sit upright for 30 to 60 minutes
   - ❑ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day
   - ❑ Renal insufficiency (creatinine clearance less than 35 ml/min)
   - ❑ History of intolerance to an oral bisphosphonate
   - ❑ Other _____
   - ❑ None of the above
   - ❑ Not applicable

10. What is the patient's pretreatment T-score? _____ ❑ Unknown
    If less than or equal to -2.5 (ex. -3, -4), no further questions.

11. What is the patient's pretreatment FRAX score for any major fracture*? _____ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

12. What is the patient's pre-treatment FRAX score for hip fracture*? _____ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

Section B: Breast and Prostate Cancer

13 *If diagnosis is breast cancer*, is the patient receiving adjuvant aromatase inhibitor therapy for breast cancer?
   ❑ Yes ❑ No ❑ Not applicable

14. *If diagnosis is prostate cancer*, is the patient receiving androgen-deprivation therapy for prostate cancer?
❑ Yes ❑ No ❑ Not applicable

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**