Outpatient Medical Injectable Prolia Authorization Request Form
Fax to 833-581-1861
(Medical Benefit Only)

Member Name: ____

Member Date of Birth: ____

Member UMI: ____

Requesting Physician's Name: ________________________NPI Number: ______________________

Requesting Physician's Address: ____

Office Contact: ___________________ Phone Number: _______________Fax Number: ___________

Facility: ____Facility NPI Number: ____________________

Facility's Address: ____

Date of Service: ____

J Code (s): ____

Diagnosis Code(s): ____

Please answer all of the following clinical questions:

Please provide T-scores from most recent DEXA and date the DEXA scan was performed.

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Has the patient tried and failed at least one bisphosphonate? If so, please list which bisphosphonate and why the patient failed. ____

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Does the patient have any contraindications to bisphosphonate therapy? If so, what is the contraindication? ____

____

Does the patient have a history of osteoporotic fracture? If so, which bone did they fracture and what was the date of the fracture? ____

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****Please verify member's eligibility and benefits through the health plan****

Fax this completed form to Highmark at 1-833-581-1861

Was a FRAX calculator used? If so, what was the patient's 10-year risk of major osteoporotic fracture and 10-year risk of hip fracture? ____

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If the patient is female:

1. Is the patient post-menopausal? ____
2. Is the patient taking an adjuvant aromatase inhibitor for breast cancer? If so, which medication? ____

If the patient is male:

1. Is the patient receiving androgen deprivation therapy for non-metastatic prostate cancer? If so, which medication is the patient receiving? ____

Any additional clinical information: ____

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****Please verify member's eligibility and benefits through the health plan****

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