HIGHMARK WESTERN NEW YORK

Outpatient Medical Injectable
Prolia Authorization Request Form
Fax to 833-619-5745
(Medical Benefit Only)

Member Name: _____

Member Date of Birth: _____

Member UMI: _____ ☐ Medicare ☐ Commercial

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): _____

☐ **Buy & Bill** ☐ **Supplied by Specialty Pharmacy** ***(****Name:* _____ *NPI:* _____**)**

Please answer the following clinical questions:

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

_____

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

How long did the member take the bisphosphonate(s) listed above? _____

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

_____

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

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

If the member is female:

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

If the member is male:

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

Fax this completed form to Highmark at 1-833-619-5745

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

Please attach all pertinent clinical information

Attached: ☐ **YES** ☐ **NO**

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

Fax this completed form to Highmark at 1-833-619-5745