Independence

**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.**