PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Prolia

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. Please provide ICD code(s) for diagnosis

Q2. Does the patient have a history of osteoporotic fracture?

☐ Yes ☐ No

Q3. Does the patient have a bone mineral density (BMD) T-score of less than or equal to -2.5?

☐ Yes ☐ No

Q4. Does the patient have a BMD T-score between -1.0 and -2.5?

☐ Yes ☐ No

Q5. Is the patient's 10 year probability of hip fracture 3% or greater?

☐ Yes ☐ No

Q6. Is the patient's 10 year probability of any major osteoporosis-related fracture 20% or greater based upon the US adapted WHO algorithm?

☐ Yes ☐ No

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Q7. Does the patient have treatment failure, intolerance, or contraindication to at least one oral bisphosphonate agent (e.g. Actonel, risedronate, Fosamax, alendronate, Boniva, ibandronate)?

☐ Yes ☐ No

Q8. Is the patient a male age 50 or older?

☐ Yes ☐ No

Q9. Is the patient a post-menopausal female?

☐ Yes ☐ No

Q10. Is the patient a male receiving androgen deprivation therapy for nonmetastatic prostate cancer?

☐ Yes ☐ No

Q11. Is the patient a female receiving adjuvant aromatase inhibitor therapy for breast cancer?

☐ Yes ☐ No

Q12. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q13. Provide name and NPI of the billing entity

Q14. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q15. Additional Comments

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Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.