AmeriHealth NEW JERSEY

Today's date:
Intended date of injection:

Prior Authorization Form – **Prolia®/Xgeva®**

ONLY COMPLETED REQUESTS WILL BE REVIEWED		
Check 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.