Prolia

Prior Authorization Request

CVS Caremark administers the medical drug prior authorization program on behalf of Harvard Pilgrim Health Care. Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form to CVS Caremark, toll-free at 1-844-851-0882** to initiate the review process. If you have questions regarding the prior authorization please contact CVS Caremark at **1-844-387-1435.**

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Patient's Name: ______________________________ **Date**: __________________________________
Patient's ID: ______________________________ **Patient's Date of Birth:** ________________
Physician's Name: ____________________________ **NPI#:** __________________________________
Specialty: ______________________________ **HPHC Provider ID#:**____________________
Physician Office Telephone: __________________ **Physician Office Fax:** ____________________

<u>Rendering</u> Provider Info: ❑ Same as Requesting Provider
Name: ____ **NPI#:** ________________________________
Fax: ______________________ **Phone:** __________________ **HPHC Provider ID:** __________________

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

<u>Additional Demographic Information:</u>

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

<u>Drug Information:</u>

*Strength/Measure*______________________________ *Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
*Directions(sig)*________________________________ *Route of administration*________________________
*Dosing frequency*______________________________

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-844-851-0882

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Prolia SGM – 10/2018.

Criteria Questions:

1. What is the diagnosis?
   - ❑ Postmenopausal osteoporosis
   - ❑ Osteoporosis in a male patient
   - ❑ Breast cancer
   - ❑ Prostate cancer
   - ❑ Glucocorticoid-induced osteoporosis
   - ❑ Other ______________________________

2. What is the ICD-10 code? __________

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Postmenopausal Osteoporosis and Osteoporosis in a Male Patient

3. *If diagnosis is osteoporosis in a male patient,* does the patient have a history of an osteoporotic vertebral or hip fracture? *If Yes, no further questions* ❑ Yes ❑ No, *skip to #9*

4. Does the patient have a history of fragility fractures? *If Yes, no further questions* ❑ Yes ❑ No

5. Does the patient have any indicators of higher fracture risk? ❑ Yes ❑ No
   If Yes, indicate the higher fracture risk inidicator: ____________________

6. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo])? ❑ Yes ❑ No

7. Has the patient had at least a 1-year trial of an oral bisphosphonate?
   ❑ Yes, ***indicate:*** ____________________________ ❑ No

8. *If patient has not had at least a 1-year trial of an oral bisphosphonate,* is there a clinical reason to avoid treatment with an oral bisphosphonate? ***Indicate below or mark "None of the above"***
   - ❑ Esophageal abnormality that delays emptying such as stricture or achalasia
   - ❑ Active upper gastrointestinal problem (e.g., dysphagia, erosive esophagitis)
   - ❑ Inability to stand or sit upright for 30 to 60 minutes
   - ❑ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day
   - ❑ Renal insufficiency (creatinine clearance less than 35 ml/min)
   - ❑ History of intolerance to an oral bisphosphonate
   - ❑ Other ______________________________
   - ❑ None of the above
   - ❑ Not applicable

9. What is the patient's pretreatment T-score? __________ ❑ Unknown
   If less than or equal to -2.5 (ex. -3, -4), no further questions.

10. What is the patient's pretreatment FRAX score for any major fracture*? __________ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

11. What is the patient's pre-treatment FRAX score for hip fracture*? __________ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

Section B: Breast and Prostate Cancer

12 *If diagnosis is breast cancer,* is the patient receiving adjuvant aromatase inhibitor therapy for breast cancer?
   ❑ Yes ❑ No ❑ Not applicable

13. *If diagnosis is prostate cancer,* is the patient receiving androgen-deprivation therapy for prostate cancer?
    ❑ Yes ❑ No ❑ Not applicable

Section C: Glucocorticoid-induced osteoporosis

14. Is the patient currently receiving or will be initiating glucocorticoid therapy? ❑ Yes ❑ No

15. Has the patient had at least a 1-year trial of an oral bisphosphonate?
    ❑ Yes, ***indicate:*** ____________________________ ❑ No

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16. *If patient has <u>not</u> had at least a 1-year trial of an oral bisphosphonate,* is there a clinical reason to avoid treatment with an oral bisphosphonate? ***Indicate below***
    - ❑ Esophageal abnormality that delays emptying such as stricture or achalasia
    - ❑ Active upper gastrointestinal problem (e.g., dysphagia, erosive esophagitis)
    - ❑ Inability to stand or sit upright for 30 to 60 minutes
    - ❑ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day
    - ❑ Renal insufficiency (creatinine clearance less than 35 ml/min)
    - ❑ History of intolerance to an oral bisphosphonate
    - ❑ Other ____

17. Does the patient have a history of a fragility fracture? *If Yes, no further questions* ❑ Yes ❑ No

18. What is the patient's pretreatment T-score? ____________ ❑ Unknown
    If less than or equal to -2.5 (ex. -3, -4), no further questions.

19. What is the patient's pretreatment FRAX score for any major fracture*? ____________ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

20. What is the patient's pre-treatment FRAX score for hip fracture*? ____________ % ❑ Unknown
    **Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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