

**Prolia**  
**Prior Authorization Request**

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

**Patient's Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Patient's ID:** \_\_\_\_\_ **Patient's Date of Birth:** \_\_\_\_\_  
**Physician's Name:** \_\_\_\_\_  
**Specialty:** \_\_\_\_\_ **NPI#:** \_\_\_\_\_  
**Physician Office Telephone:** \_\_\_\_\_ **Physician Office Fax:** \_\_\_\_\_

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

**Additional Demographic Information:**

*Patient Weight:* \_\_\_\_\_ *kg*  
*Patient Height:* \_\_\_\_\_ *ft* \_\_\_\_\_ *inches*

**Criteria Questions:**

1. What is the diagnosis?  
 Postmenopausal osteoporosis  
 Osteoporosis in a male patient  
 Breast cancer  
 Prostate cancer  
 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 indicator:*** \_\_\_\_\_
6. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (i.e., 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

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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 (eg, 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 30 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

***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)**