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 inidicator: _____

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

8. *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 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*

<u>Section B: Breast and Prostate Cancer</u>

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)**