HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
PROLIA®, XGEVA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 801-213-1547. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans: 855-869-4769, Commercial Groups: 855-859-4892, MHC: 855-885-7695, Advantage U Part B: 888-605-0858

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		HCPCS Code:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Prolia® (denosumab), ☐ XGEVA® (denosumab)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
PROLIA® FOR OSTEOPROSIS			
1. Has the patient been diagnosed with osteoporosis?	☐	☐	**Please provide documentation**
2. Is the patient 18 years of age or older?	☐	☐	
3. Does the patient have a documented baseline bone mineral density (BMD) T-score of ≤ -2.5 by DEXA scan?	☐	☐	**Please provide documentation**
4. Has the patient had a 12-month trial and failure to a bisphosphonate?	☐	☐	**Please provide documentation**
5. Will the patient be taking calcium 1000mg daily and at least 400 IU vitamin daily?	☐	☐	**Please provide documentation**
PROLIA® FOR BONE LOSS SECONDARY TO AROMATASE INHIBITORS			
1. Has the patient been diagnosed with breast cancer and currently taking an aromatase inhibitor?	☐	☐	**Please provide documentation**
2. Is the patient 18 years of age or older?	☐	☐	
3. Does the patient have a documented baseline bone mineral density (BMD) T-score of ≤ -1.0 by DEXA scan?	☐	☐	**Please provide documentation**
4. Has the patient had a 12-month trial and failure to a bisphosphonate?	☐	☐	**Please provide documentation**

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5. Will the patient be taking calcium 1000mg daily and at least 400 IU vitamin daily?	☐	☐	**Please provide documentation**
PROLIA® FOR HORMONE- SENSITIVE PROSTATE CANCER			
1. Has the patient been diagnosed with Hormone-Sensitive Prostate Cancer and currently taking androgen deprivation therapy?	☐	☐	**Please provide documentation**
2. Is the patient 18 years of age or older?	☐	☐	
3. Does the patient have a FRAX score of 10 year probability of hip fracture ≥3% or a 10 year probability of major osteoporosis-related fracture of ≥20%?	☐	☐	**Please provide documentation**
4. Has the patient had a 12-month trial and failure to a bisphosphonate?	☐	☐	**Please provide documentation**
5. Will the patient be taking calcium 1000mg daily and at least 400 IU vitamin daily?	☐	☐	**Please provide documentation**
XGEVA®			
6. Has the patient been diagnosed with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity?	☐	☐	**Please provide documentation**
7. Is the patient 18 years of age or older?	☐	☐	
8. Does the patient have a diagnosis of metastatic bone disease from solid tumor and has had a trial and failure to a bisphosphonate?	☐	☐	**Please provide documentation**
9. Has the patient been diagnosed with hypercalcemia of malignancy refractory to bisphosphonate therapy?	☐	☐	**Please provide documentation**
10. Will the patient we taking calcium 1000mg daily and at least 400 IU vitamin daily?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Has the therapy shown to be effective with an improvement or stabilization in condition?	☐	☐	**Please provide documentation**
4. Does the member have a continued medical need for the therapy?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

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Physician's Signature:

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- M006
Origination Date: 08/07/2017
Reviewed/Revised Date: 05/20/2020
Next Review Date: 05/20/2021
Current Effective Date: 06/01/2020

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