Aetna Better Health®

Fax completed prior authorization request form to 877-270-3298 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at
https://www.aetnabetterhealth.com/maryland/providers/pharmacy-prior-authorization.html

Injectable Osteoporosis Agents
Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information							
Member Name (first & last):	Date of Birth:	Gender: ☐ Male ☐ Female		Height:			
Member ID:	City:	State:		Weight:			
Prescribing Provider Information							
Provider Name (first & last):	Specialty:	NPI#	DEA#				
Office Address:	City:	State:	Zip Code:				
Office Contact:	Office Phone	Office Fax:					
Dispensing Pharmacy Information							
Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:					
Requested Medication Information							
Preferred Agents:	☐ **Prolia**	☐ **teriparatide**	☐ **Tymlos**				
Non-Preferred Agents:	☐ Evenity	☐ Forteo	☐ zoledronic acid				
	☐ Other, please specify:						
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): ☐Yes ☐No	ICD-10 Code:	Diagnosis:					
What medication(s) have been tried and failed for diagnosis?							
Are there any contraindications to formulary medications? If yes, please specify:	☐ Yes	☐ No	☐ Initial request	☐ Continuation of therapy request			
If continuation of therapy, is there documentation to support member is benefiting from therapy (for example, improved or stabilized BMD, no new fractures)?					☐ Yes	☐ No	
Directions for Use:	Strength:		Dosage Form:				
	Quantity:	Day Supply:	Duration of Therapy/Use:				
Turn-Around Time for Review							
☐ Standard – (24 hours)	☐ **Urgent** – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____						
Clinical Information							
Will member be supplemented with adequate calcium and vitamin D ? (exception: Forteo, teriparatide)	☐ Yes	☐ No	☐ N/A	Is there a contraindication to requested drug?	☐ Yes	☐ No	
☐ **Prolia ONLY:**							
Is member pregnant?	☐ Yes	☐ No	Does member have hypocalcemia?		☐ Yes	☐ No	
☐ **Zoledronic Acid ONLY:**							
Does member have hypocalcemia?	☐ Yes	☐ No	Is members' CrCl <35mL/min?	☐ Yes	☐ No	Does member have acute renal impairment?	☐ Yes ☐ No
☐ **Evenity ONLY:**						☐ Yes	☐ No

Does member have hypocalcemia OR MI OR stroke within preceding year?					☐ Yes	☐ No	
Additional Clinical Information							
Is diagnosis of osteoporosis (T-score < -2.5 OR fragility fracture at hip, spine, wrist, arm, rib OR pelvis)?					☐ Yes	☐ No	
Did member have failure with oral OR IV bisphosphonate despite compliance, including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate?					☐ Yes	☐ No	
Is there contraindication OR severe intolerance to oral bisphosphonate? (For example, current upper GI symptoms, inability to swallow, inability to remain in upright position after oral bisphosphonate administration)?					☐ Yes	☐ No	
☐ **Request for males**							
Is testosterone level normal for lab reference range?	☐ Yes	☐ No	Is member hypogonadal?	☐ Yes	☐ No	☐ N/A	
Will testosterone replacement therapy be prescribed before starting treatment?	☐ Yes	☐ No	Does member have history of prostate cancer?	☐ Yes	☐ No		
☐ **Prevention of Osteoporosis in Postmenopausal Women**							
Is diagnosis of osteopenia (T-score between -1.0 and -2.5) AND high risk for osteoporosis fracture?	☐ Yes	☐ No	Fracture Risk Assessment Tool risk ≥3.0% for hip fracture OR ≥ 20% for any major osteoporosis related fracture OR multiple risk factors for fracture?		☐ Yes	☐ No	
Was there failure of oral OR IV bisphosphonate despite compliance, including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate?	☐ Yes	☐ No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position after oral bisphosphonate administration)?		☐ Yes	☐ No	
☐ **Renewal Request ONLY**							
Does member have a stable BMD without fractures?	☐ Yes	☐ No	Has BMD has worsened OR member had fractures?		☐ Yes	☐ No	
☐ **Glucocorticoid-Induced Osteoporosis**							
Is member a postmenopausal woman OR man >50 years of age?	☐ Yes	☐ No	Has member received OR is expected to receive, prednisone ≥7.5mg/day for > 3 months?		☐ Yes	☐ No	
Is member premenopausal woman or man <50 years of age?	☐ Yes	☐ No	Does member have history of fragility fracture AND received OR is expected to receive, prednisone ≥7.5mg/day for >3 months?		☐ Yes	☐ No	
Was there failure of oral OR IV bisphosphonate despite compliance (including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate)?	☐ Yes	☐ No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position, after oral bisphosphonate administration)?		☐ Yes	☐ No	
☐ **Renewal Request ONLY**							
While on treatment, does the member have stable bone mineral density without fractures?	☐ Yes	☐ No	While on treatment, has bone mineral density has worsened, or member had fractures?		☐ Yes	☐ No	
☐ **Bone Metastases of Cancer AND Multiple Myeloma**							
Does member have diagnosis of solid tumor with bone metastases?	☐ Yes	☐ No	Does member have diagnosis of multiple myeloma?		☐ Yes	☐ No	
Does member have diagnosis of castration-resistant prostate cancer with bone metastases?					☐ Yes	☐ No	
☐ **Increase of Bone Mass in MEN on Androgen Deprivation Therapy for Prostate Cancer WITHOUT Bone Metastases**							
Is member at high risk for osteoporosis fracture (FRAX risk ≥3.0% for hip fracture OR ≥20% for any major osteoporosis related fracture OR multiple risk factors for fracture)?					☐ Yes	☐ No	
Was there failure of oral OR IV bisphosphonate despite compliance (including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate)?	☐ Yes	☐ No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position, after oral bisphosphonate administration)?		☐ Yes	☐ No	
☐ **Increase of Bone Mass in WOMEN on Aromatase Inhibitory therapy for Breast Cancer WITHOUT Bone Metastases**							
Is member POST-menopausal OR PRE-menopausal with diagnosis of osteoporosis (T-score < -2.5 OR fragility fracture at hip, spine, wrist, arm, rib OR pelvis)?					☐ Yes	☐ No	

Was there failure of oral OR IV bisphosphonate despite compliance (including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate)?	☐ Yes	☐ No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position, after oral bisphosphonate administration)?	☐ Yes	☐ No
☐ **Hypercalcemia of Malignancy**					
Does member have moderate OR severe hypercalcemia associated with malignancy?	☐ Yes	☐ No	Is member receiving vigorous saline hydration with goal of increasing urine output to about 2 L/day?	☐ Yes	☐ No
☐ **Paget's Disease of Bone**					
Does member have bone specific alkaline phosphatase > 2 times ULN, OR symptoms related to active Paget's (pain at site of pagetic lesion)?				☐ Yes	☐ No
Is there normal serum calcium, phosphorus AND 25-hydroxyvitamin D (based on reference range for lab)?	☐ Yes	☐ No	If ABNORMAL serum calcium, phosphorus AND 25-hydroxyvitamin D, will abnormalities be treated before starting IV bisphosphonates?	☐ Yes	☐ No
Was there failure of oral OR IV bisphosphonate despite compliance (including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate)?	☐ Yes	☐ No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position, after oral bisphosphonate administration)?	☐ Yes	☐ No
☐ **Renewal Request ONLY**					
Has bone specific alkaline phosphatase risen after initial treatment?	☐ Yes	☐ No	Does member have symptoms?	☐ Yes	☐ No
Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records					

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ **Date:** _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Standard turnaround time is 24 hours. You can call 866-827-2710 to check the status of a request.