Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Prolia (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Prolia (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

PROLIA (denosumab)

Other, Please specify: _____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Is this a renewal request for a patient who has a previous authorization on file for Prolia with this health plan? Y N

   [If no, skip to question 5.]

2. Does the patient have osteoporosis? Y N

   [If no, then no further questions.]

3. Has the patient received Prolia for 5 years or more? Y N

   [If no, then no further questions.]

4. Has the patient's bone mineral density (BMD) worsened OR has the patient had a fracture while receiving Prolia? Y N

   [No further questions.]

5. Is Prolia requested for the treatment of osteoporosis in a man or a postmenopausal woman? Y N

   [If no, skip to question 11.]

6. Does the patient have a low bone density less than 2.5 SD (standard deviations) below normal (T-score -2.5 or less) OR does the patient have a fragility fracture at the hip, spine, wrist, arm, rib, or pelvis? Y N

   If yes, submit records or document T-score and date:
   _____

   [If no, then no further questions.]

7. Is the request for a male patient? Y N

   [If no, skip to question 16.]

8. Does the patient have normal testosterone levels? Y N

   Submit labs or document result and date:
   _____

   [If yes, skip to question 16.]

9. Is the patient receiving testosterone replacement therapy? Y N

   [If yes, skip to question 16.]

10. Does the patient have a history of prostate cancer? Y N

    [If yes, skip to question 16.]

    [If no, then no further questions.]

11. Is Prolia requested for the prevention of osteoporosis in a man with prostate cancer who is receiving androgen deprivation therapy? Y N

    [If no, skip to question 13.]

12. Is the patient at high risk for osteoporotic fracture as evidenced by ANY of the following? A) FRAX risk score of at least 3% for hip fracture, B) FRAX risk score of at least 20% for any major osteoporotic fracture, or C) Has multiple risk factors for fracture (low BMI, previous fragility fracture, hip fracture in a parent, current smoker, alcohol intake of 3 or more units per day, or rheumatoid arthritis) Y N

    If yes, submit records or document here:

    _____

    [If no, then no further questions.]

    [If yes, skip to question 16.]

13. Is Prolia requested for the prevention of osteoporosis in a woman with breast cancer who is receiving an aromatase inhibitor? Y N

    [If no, then no further questions.]

14. Is the patient postmenopausal? Y N

    [If yes, skip to question 16.]

15. Does the patient have a low bone density less than 2.5 SD (standard deviations) below normal (T-score -2.5 or less) OR does the patient have a fragility fracture at the hip, spine, wrist, arm, rib, or pelvis? Y N

    If yes, submit records or document T-score and date:

    _____

    [If no, then no further questions.]

16. Does the patient meet ONE of the following? A) Decreased T-score after at least 2 years of compliant therapy with at least one formulary oral bisphosphonate (i.e., alendronate), B) New fracture while taking an oral bisphosphonate (i.e., alendronate), or C) Contraindication or SEVERE intolerance to oral bisphosphonates (i.e., current upper GI symptoms, inability to swallow, or inability to remain in an upright position after oral bisphosphonate administration for the required length of time) Y N

If yes, submit records or provide details here:

_____

[If no, then no further questions.]

17. Does the patient have a 25-hydroxyvitamin D level above 20ng/mL? Y N

    (Note: Patients who are vitamin D deficient should have vitamin D replaced before starting treatment with Prolia.)

    If yes, submit labs or document result and date:

    _____

    [No further questions.]

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date