

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS

Prolia (IL88)

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 1-855-684-5250.

Please contact Aetna Better Health Illinois at 1-866-212-2851 with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Prolia (IL88).

Drug Name (select from list of drugs shown)

Prolia (denosumab)

denosumab

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: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Please circle the appropriate answer for each question.

1. Is the patient at least 18 years of age or older? Y N

[If no, no further questions.]

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

[If no, no further questions.]

3. Is the patient receiving concomitant elemental calcium supplementation of 1200-1500 mg and 400-1000 IU of vitamin D supplementation per day? Y N

[If no, no further questions.]

4. Is the patient currently receiving Prolia? Y N

[If yes, skip to question 8.]

5. Does the patient have a documented failure of consecutive 6-month therapy of formulary oral bisphosphonate (e.g. alendronate)? Failure to therapy is defined as follows: PLEASE LIST THE MEDICATION TRIED AND DOCUMENT FAILURE (INCLUDE T-SCORE AND DATE, IF APPLICABLE): \_\_\_\_\_

Y N

Decrease in T-score in comparison with baseline T-score from DEXA scan OR \ New fracture

[If yes, skip to question 7.]

6. Is/was the patient contraindicated or intolerant to at least one formulary oral bisphosphonate? PLEASE LIST THE MEDICATION TRIED AND INTOLERANCE/ CONTRAINDICATION: \_\_\_\_\_

Y N

[If no, no further questions.]

7. Does the patient meet one of the following? PLEASE DOCUMENT T-SCORE AND DATE: \_\_\_\_\_

Y N

T-score less than or equal to -2.5 at the spine, femoral neck OR \ T-score between -1.0 and -2.5 (femoral neck or spine) at high 10-year risk of fracture using the US-adapted FRAX tool available at [www.shef.ac.uk/FRAX](http://www.shef.ac.uk/FRAX) (greater than or equal to 3% for hip fracture or greater than or equal to 20% for a major osteoporosis-related fracture) OR \ History hip or spine fracture

[No further questions.]

8. Is the patient responding to Prolia treatment?

Y N

Comments:

\_\_\_\_\_

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

\_\_\_\_\_  
Prescriber (Or Authorized) Signature

\_\_\_\_\_  
Date