Independence
Independence Administrators

Today's date: _____ **Intended date of injection:** _____

Prior Authorization Form – Prolia® / Xgeva®

ONLY COMPLETED REQUESTS WILL BE REVIEWED.

Select one: ☐ **Prolia®** ☐ **Xgeva®** **Check one:** ☐ New start ☐ Continued treatment

Patient information (please print)	**Physician information (please print)**	
Patient name	Prescribing physician	
Address	Office address	
City, state, ZIP	City, state, ZIP	
Patient telephone #	Office contact	
Patient ID	Office telephone #	
Date of Birth	Fax #	NPI

☐ **No delivery requested; physician will use office supply. Authorization only.**
☐ **Delivery requested to the physician's office.**

**** A copy of the prescription must accompany the medication request for delivery.****

1) **Diagnosis for drug requested (must include ICD-10):** _____
2) **Patient medical information**
   a. T-score (required; fax DEXA results and date of most recent measurement) _____
   b. Is the patient post-menopausal? ☐ Yes ☐ No
   c. Does the patient have a history of osteoporotic non-collision fracture (e.g., vertebral, hip, nonvertebral)? ☐ Yes ☐ No
   d. Does the patient have multiple risk factors for fracture (e.g., endocrine disorders; gastrointestinal disorders; use of medications associated with low bone mass or bone loss, such as corticosteroids)? ☐ Yes ☐ No
   e. Does the patient have documented bone metastases from a solid tumor? ☐ Yes ☐ No
   f. Does the patient have a history of any of the following? (check all that apply) ☐ Yes ☐ No
      ☐ Documented history of failure, contraindication, or intolerance due to side effects to at least one other osteoporosis medicine (e.g., oral bisphosphonates, calcitonin, estrogens);
      ☐ Documented inadequate response to at least one other osteoporosis medicine (e.g., oral bisphosphonates; estrogens) after a 12-month trial;
      ☐ Severely deteriorated condition such that the osteoporosis is so significant that a trial of oral bisphosphonates is not medically warranted;
      ☐ Receiving adjuvant aromatase inhibitor therapy for **breast cancer** with _____ (list drug);
      ☐ Receiving androgen deprivation therapy for **nonmetastatic prostate cancer** with _____ (list drug);
      ☐ Giant cell tumor of the bone, which is either unresectable or in a location where surgical resection is likely to result in severe morbidity;
      ☐ Documented renal insufficiency.
3) **Prescription Information**

   Quantity _____ Refill x _____ month(s)
   Instructions (include dose) _____ Every _____ day(s)/ week(s)/ month(s)
   Physician's Signature: _____

Please fax this completed form to 215-784-0672.

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