Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Prolia

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Request Type:

☐ Initial - Go to 2 ☐ Continuation - Go to 12

Q2. Diagnosis:

☐ Postmenopausal osteoporosis - Go to 3
☐ Osteoporosis in men - Go to 5
☐ Glucocorticoid-induced osteoporosis - Go to 7
☐ Breast cancer - Go to 10
☐ Prostate cancer - Go to 11

Q3. Does the patient have a history of fragility fractures? Attach supporting chart notes or medical records.

☐ Yes ☐ No

Q4. Does the patient have a pre-treatment T-score less than or equal to -2.5 OR member has osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability and meets ANY of the following criteria:

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Patient Name:	**Prescriber Name:**

A) Patient has indicators of very high fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores [less than or equal to -3], or increased fall risk)
B) Patient has failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo, Bonsity], abaloparatide [Tymlos])
C) Patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate?
Must attach supporting chart notes or medical records.

☐ Yes ☐ No

Q5. Does the patient have a history of an osteoporotic vertebral or hip fracture fractures (supporting chart notes or medical records attached)?

☐ Yes ☐ No

Q6. Does the patient meets BOTH of the following criteria:
A) Patient has a pre-treatment T-score less than or equal to -2.5 OR member has osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability
B) Patient has had an oral OR injectable bisphosphonate trial of at least 1-year duration OR there is a clinical reason to avoid treatment with a bisphosphonate?
Must attach supporting chart notes or medical records.

☐ Yes ☐ No

Q7. Is the patient currently receiving or will be initiating glucocorticoid therapy at an equivalent prednisone dose of greater than or equal to 2.5 mg/day for greater than or equal to 3 months?

☐ Yes ☐ No

Q8. Has the patient had an oral OR injectable bisphosphonate trial of at least 1-year duration OR there is a clinical reason to avoid treatment with a bisphosphonate?

☐ Yes ☐ No

Q9. Does the patient meet ANY of the following criteria:
A) Patient has a history of a fragility fracture
B) Patient has a pre-treatment T-score less than or equal to -2.5

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Patient Name:	**Prescriber Name:**

C) Patient has osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability?
Must attach supporting chart notes or medical records.

☐ Yes ☐ No

Q10. Is the patient receiving adjuvant aromatase inhibition therapy for breast cancer?

☐ Yes ☐ No

Q11. Is the patient receiving androgen deprivation therapy for prostate cancer?

☐ Yes ☐ No

Q12. Has the patient received less than 24 months of therapy and has experienced clinical benefit (e.g., no new fracture seen on radiography) and has not experienced clinically significant adverse events during therapy?

☐ Yes ☐ No

Q13. Has the patient experienced clinical benefit as evidenced by a bone mass measurement showing an improvement or stabilization in T-score compared with the previous bone mass measurement and member has not experienced any adverse effects?

☐ Yes ☐ No

Q14. Additional Information:

_____ _____

Prescriber Signature Date