



Prolia® (denosumab) Injectable Medication Precertification Request

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

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(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
Phone: 1-866-503-0857
FAX: 1-844-268-7263

Please indicate: Start of treatment: Start date ____/____/____
 Continuation of therapy, Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:			City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:		Email:	
Patient Current Weight: _____ lbs or _____ kgs		Patient Height: _____ inches or _____ cms		Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #:	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #:	If yes, provide ID#: _____ Carrier Name: _____
Insured:	Insured:
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.	
Address:			City:	State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	
Specialty (Check one): <input type="checkbox"/> Oncologist <input type="checkbox"/> Hematologist <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Primary Care <input type="checkbox"/> GYN <input type="checkbox"/> Other: _____					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	Dispensing Provider/Pharmacy: Patient Selected choice <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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E. PRODUCT INFORMATION

Request is for: Prolia (denosumab) Dose: _____ Frequency: _____

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For Initiation Requests (clinical documentation required for all requests):

Breast cancer
 Yes No Is the patient receiving adjuvant aromatase inhibition therapy for breast cancer?

Glucocorticoid-induced osteoporosis
 Yes No 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 Does the patient have a history of a fragility fracture?
→ Please indicate the patient's pre-treatment T-score:
 -2.5 or below (e.g., -2.6, -2.7, -3) between -2.5 and -1 (e.g., -2.4, -2.3, -2) -1 or above (e.g., -0.9, -0.8, -0.5) unknown
Please indicate the patient's pre-treatment FRAX score for any major fracture:
 less than 20% greater than or equal to 20% unknown
Please indicate the patient's pre-treatment FRAX score for hip fracture: less than 3% greater than or equal to 3% unknown

Yes No Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate?
→ Yes No Is there a clinical reason to avoid treatment with a bisphosphonate?
→ Please indicate reason: presence of anatomic or functional esophageal abnormalities that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility) active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders, etc.) inability to stand or sit upright for 30 to 60 minutes inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day renal insufficiency (creatinine clearance less than 35 mL/min) history of intolerance to an oral bisphosphonate
 other, please explain: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

Osteoporosis in men

Yes No Does the patient have a history of an osteoporotic vertebral or hip fracture?

→ Please indicate the patient's pre-treatment T-score:
 -2.5 or below (e.g., -2.6, -2.7, -3) between -2.5 and -1 (e.g., -2.4, -2.3, -2) -1 or above (e.g., -0.9, -0.8, -0.5) unknown

Please indicate the patient's pre-treatment FRAX score for any major fracture: less than 20% greater than or equal to 20% unknown

Please indicate the patient's pre-treatment FRAX score for hip fracture: less than 3% greater than or equal to 3% unknown

Yes No Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate?

→ Yes No Is there a clinical reason to avoid treatment with a bisphosphonate?

→ Please indicate reason: presence of anatomic or functional esophageal abnormalities that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility) active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders, etc.) inability to stand or sit upright for 30 to 60 minutes inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day renal insufficiency (creatinine clearance less than 35 mL/min) history of intolerance to an oral bisphosphonate other, please explain: _____

Postmenopausal osteoporosis

Yes No Does the patient have a history of fragility fractures?

→ Please indicate the patient's pre-treatment T-score:
 -2.5 or below (e.g., -2.6, -2.7, -3) between -2.5 and -1 (e.g., -2.4, -2.3, -2) -1 or above (e.g., -0.9, -0.8, -0.5) unknown

Please indicate the patient's pre-treatment FRAX score for any major fracture: less than 20% greater than or equal to 20% unknown

Please indicate the patient's pre-treatment FRAX score for hip fracture: less than 3% greater than or equal to 3% unknown

Yes No Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo, Bonsity], abaloparatide [Tymlos])?

→ Yes No Has the patient had at least a 1-year trial of an oral bisphosphonate?

→ Yes No Is there a clinical reason to avoid treatment with an oral bisphosphonate?

→ Yes No Does the patient have any indicators of very high fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores [-3 or below], increased fall risk)?

→ Please indicate reason: presence of anatomic or functional esophageal abnormalities that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility) active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders, etc.) inability to stand or sit upright for 30 to 60 minutes inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day renal insufficiency (creatinine clearance less than 35 mL/min) history of intolerance to an oral bisphosphonate other, please explain: _____

Prostate cancer

Yes No Is the patient receiving androgen deprivation therapy for prostate cancer?

For Continuation Requests (clinical documentation required for all requests):

Yes No Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

Yes No 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?

→ Please indicate the length of time the patient has been receiving the requested medication: _____ (months)

Yes No Has the patient experienced a clinical benefit from therapy (e.g., no new fracture seen on radiography)?

Yes No Has the patient experienced any adverse effects during therapy?

H. ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ Date: ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.