Premier Health Plan

Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

PROLIA
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Drug Requested:	Strength:	Directions:
Quantity Dispensed:	Day Supply:	□ Generic □ Brand Necessary

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Billing Information

□ Billed by **PHARMACY** dispensed to the member *or* provider for administration.	□ Billed under **MEDICAL** benefit by provider. J CODE:_______________________ ICD-10 Code:___________________	Place of Administration: □ Physician's Office □ Hospital/Clinic □ Patient Home

Clinical Information

Diagnosis:	Date Diagnosed:

Please provide baseline bone mineral density (BMD) T score:_____________ Date of test:__________________

Please provide current bone mineral density (BMD) T score:_____________ Date of test:__________________

Please provide BMD skeletal site measured:____

If the BMD T score is > -2.5, please provide the following:

- 10-year probability of a hip fracture based on the World Health Organization algorithm: _________
- 10-year probability of a major osteoporosis-related fracture: _________

Does the member have a history of fracture? □Yes □No

If yes, please indicate fracture site: __________________________________ Date of Fracture:______________

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Member Name:	DOB:	Health Plan ID:

Please be sure to complete and include this page with the 1st page of this form.

Has the member previously tried and failed Oral AND IV bisphosphonate therapy? ☐Yes ☐No

If yes, please list: ____

Please provide any additional information which should be considered in the space below:

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