Premier Health Plan

Premier Health Plan
Pharmacy Services
Phone: 866-822-2714
Fax: 855-862-6518

PROLIA
Prior Authorization Form

□ Standard Request (72 hours) □ Expedited Request (24 hours)	If you or your prescriber believe that waiting 72 hours for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. For expedited requests you will receive a decision within 24 hours. You cannot request an expedited coverage determination if you are requesting reimbursement for a drug you already received.

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:_____

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

If yes, please indicate fracture site: _____ Date of Fracture:_____

Has the patient trial and failed bisphosphonate therapy (please list agent(s)? □Yes □No

Is the patient on aromatase inhibitor therapy? □Yes □No

Is the patient on androgen deprivation therapy? □Yes □No

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