



Fax completed prior authorization request form to 800-854-7614 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts.

All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**

Pharmacy Coverage Guidelines are available at www.mercycareaz.org/providers/chp-forproviders/pharmacy

Injectable Osteoporosis Agents Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.

REQUIRED: Office notes, labs and medical testing relevant to request showing medical justification are required to support diagnosis

Member Information										
Member Name (first & last):			Date of Birth:		Gender:			Height:		
					<input type="checkbox"/> Male	<input type="checkbox"/> Female				
Member ID:			City:		State:			Weight:		
Prescribing Provider Information										
Provider Name (first & last):			Specialty:		NPI#		DEA#			
Office Address:			City:		State:			Zip Code:		
Office Contact:				Office Phone			Office Fax:			
Dispensing Pharmacy Information										
Pharmacy Name:				Pharmacy Phone:			Pharmacy Fax:			
Requested Medication Information										
Preferred Agents:			<input type="checkbox"/> Forteo		<input type="checkbox"/> Prolia					
Is request for a Non-Preferred agent?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has the member had a trial and failure with ALL the preferred agents?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Medication request is NOT for an FDA- approved, or compendia-supported diagnosis (circle one): Yes No				ICD-10 Code:			Diagnosis:			
What medication(s) have been tried and failed for diagnosis?										
Are there any contraindications to formulary medications? If yes, please specify:				<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Initial request		<input type="checkbox"/> Continuation of therapy request		
If continuation of therapy, is there documentation to support member is benefiting from therapy (for example, improved or stabilized BMD, no new fractures)?							<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Directions for Use:			Strength:			Dosage Form:				
			Quantity:		Day Supply:		Duration of Therapy/Use:			
Turn-Around Time for Review										
<input type="checkbox"/> Standard – (24 hours)				<input type="checkbox"/> Urgent – If waiting 24 hours for a standard decision could seriously harm life, health, or ability to regain maximum function, you can ask for an expedited decision. Signature: _____						
Clinical Information										
Will member be supplemented with adequate calcium and vitamin D ? (exception: Forteo, teriparatide)			<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Is there a contraindication to requested drug?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Prolia ONLY:										
Is member pregnant?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have hypocalcemia?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Zoledronic Acid ONLY:										
Does member have hypocalcemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is members' CrCl <35mL/min?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have acute renal impairment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
<input type="checkbox"/> Evenity ONLY:										
Does member have hypocalcemia OR MI OR stroke within preceding year?							<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Additional Clinical Information										
Is diagnosis of osteoporosis (T-score < -2.5 OR fragility fracture at hip, spine, wrist, arm, rib OR pelvis)?							<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Did member have failure with oral OR IV bisphosphonate despite compliance, including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate?							<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Is there contraindication OR severe intolerance to oral bisphosphonate? (For example, current upper GI symptoms, inability to swallow, inability to remain in upright position after oral bisphosphonate administration)?							<input type="checkbox"/> Yes	<input type="checkbox"/> No		

<input type="checkbox"/> Request for males						
Is testosterone level normal for lab reference range?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member hypogonadal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
Will testosterone replacement therapy be prescribed before starting treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have history of prostate cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Prevention of Osteoporosis in Postmenopausal Women						
Is diagnosis of osteopenia (T-score between -1.0 and -2.5) AND high risk for osteoporosis fracture?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fracture Risk Assessment Tool risk $\geq 3.0\%$ for hip fracture OR $\geq 20\%$ for any major osteoporosis related fracture OR multiple risk factors for fracture?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was there failure of oral OR IV bisphosphonate despite compliance, including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position after oral bisphosphonate administration)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Renewal Request ONLY						
Does member have a stable BMD without fractures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has BMD worsened OR member had fractures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Glucocorticoid-Induced Osteoporosis						
Is member a postmenopausal woman OR man >50 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Has member received OR is expected to receive, prednisone $\geq 7.5\text{mg/day}$ for > 3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is member premenopausal woman or man <50 years of age?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have history of fragility fracture AND received OR is expected to receive, prednisone $\geq 7.5\text{mg/day}$ for >3 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was there failure of oral OR IV bisphosphonate despite compliance (including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position, after oral bisphosphonate administration)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Renewal Request ONLY						
While on treatment, does the member have stable bone mineral density without fractures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	While on treatment, has bone mineral density worsened, or member had fractures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Bone Metastases of Cancer AND Multiple Myeloma						
Does member have diagnosis of solid tumor with bone metastases?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have diagnosis of multiple myeloma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Does member have diagnosis of castration-resistant prostate cancer with bone metastases?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Increase of Bone Mass in MEN on Androgen Deprivation Therapy for Prostate Cancer WITHOUT Bone Metastases						
Is member at high risk for osteoporosis fracture (FRAX risk $\geq 3.0\%$ for hip fracture OR $\geq 20\%$ for any major osteoporosis related fracture OR multiple risk factors for fracture)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was there failure of oral OR IV bisphosphonate despite compliance (including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position, after oral bisphosphonate administration)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Increase of Bone Mass in WOMEN on Aromatase Inhibitory therapy for Breast Cancer WITHOUT Bone Metastases						
Is member POST-menopausal OR PRE-menopausal with diagnosis of osteoporosis (T-score < -2.5 OR fragility fracture at hip, spine, wrist, arm, rib OR pelvis)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Was there failure of oral OR IV bisphosphonate despite compliance (including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position, after oral bisphosphonate administration)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Hypercalcemia of Malignancy						
Does member have moderate OR severe hypercalcemia associated with malignancy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Is member receiving vigorous saline hydration with goal of increasing urine output to about 2 L/day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Paget's Disease of Bone						
Does member have bone specific alkaline phosphatase > 2 times ULN, OR symptoms related to active Paget's (pain at site of pagetic lesion)?				<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Is there normal serum calcium, phosphorus AND	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If ABNORMAL serum calcium,	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

25-hydroxyvitamin D (based on reference range for lab)?			phosphorus AND 25-hydroxyvitamin D, will abnormalities be treated before starting IV bisphosphonates?		
Was there failure of oral OR IV bisphosphonate despite compliance (including new fracture OR reduction in BMD per recent DEXA scan, after TWO years of oral bisphosphonate)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Was there a contraindication OR severe intolerance to oral bisphosphonate (current upper GI symptoms, inability to swallow OR inability to remain in upright position, after oral bisphosphonate administration)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Renewal Request ONLY

Has bone specific alkaline phosphatase risen after initial treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Does member have symptoms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Additional information the prescribing provider feels is important to this review. Please specify below or submit medical records

Signature affirms that information given on this form is true and accurate and reflects office notes.

Prescribing Provider's Signature: _____ Date: _____

Please note: Incomplete forms or forms without the chart notes will be returned

Office notes, labs, and medical testing relevant to the request that show medical justification are required.
Standard turnaround time is 24 hours. You can call 833-711-0776 to check the status of a request.