Prolia® (denosumab) Injectable Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021 (TTY:711)
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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 #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured:

Medicare: ☐ Yes ☐ No If yes, provide ID #: **Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:	Last Name:			*(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:			Phone:	

Specialty *(Check one):* ☐ **Oncologist** ☐ **Hematologist** ☐ **Internal Medicine** ☐ **Primary Care** ☐ **GYN** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

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 ALL Requests (clinical documentation required):
☐ Yes ☐ No Will the requested drug be administered by a healthcare professional?

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

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.