UnitedHealthcare Community Plan

Bone Density Regulators - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- **Is the patient female? □ Yes □ No**
  If yes, is the patient postmenopausal? □ Yes □ No
- **List T-score: _____** ***(at the femoral neck, total hip, or lumbar spine)***
- **Is the patient at high risk for fracture? □ Yes □ No**
- **Is the patient at high risk for fracture as defined by bone mineral density (BMD) that is 2.5 or more standard deviations below that of a "young normal" adult? □ Yes □ No**
- **Does the patient have a diagnosis of osteoporosis? □ Yes □ No**
- **Does the patient have a history of previous fractures or glucocorticoid use for at least 3 months at a dose of 5 mg per day of prednisone (or equivalent)? □ Yes □ No**

Requests for TYMLOS & FORTEO:

- **Is the patient at high risk for fracture as defined by a diagnosis of osteopenia? □ Yes □ No**
- **Does the patient have history of contraindication, or intolerance to at least two oral bisphosphonates and one selective estrogen receptor modulator (SERM) (e.g., raloxifene)? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
- **Does the patient have history of failure to a two (2) year trial of one oral bisphosphonate or one selective receptor modulator (SERM) (e.g., raloxifene)? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
- **Has the total combined duration of parathyroid hormone (e.g., Tymlos, Forteo) therapy exceeded 2 years? □ Yes □ No**
- **Does the patient have an increase in bone mass with primary or hypogonadal osteoporosis at high risk for fracture? □ Yes □ No**
- **Does the patient have a diagnosis of osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture? □ Yes □ No**
- **Is the patient 18 years of age or older with closed epiphyses? □ Yes □ No**

Requests for PROLIA:

- **Is the patient a man receiving androgen deprivation therapy (ADT) for non-metastatic prostate cancer? □ Yes □ No**
- **Is the patient a woman who is receiving adjuvant aromatase inhibitor (AI) therapy for breast cancer? □ Yes □ No**
- **Does the patient have history of failure, contraindication, or intolerance to at least one (1) oral bisphosphonate and IV zolendronic acid? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
- **Does any of the following apply: □ Yes □ No (check which applies)**
  □ Prescribed for the prevention of osteoporosis or for the prevention or treatment of glucocorticoid-induced osteoporosis
  □ Uncorrected pre-existing hypocalcemia
  □ Currently pregnant
  □ Currently receiving XGEVA (denosumab)

Requests for CONTINUATION OF THERAPY:

- **Is there documentation of positive clinical benefit? □ Yes □ No**

Provider Signature: _____ **Date:** _____