

## 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: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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 zoledronic 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:** \_\_\_\_\_

**Confidentiality Notice:** This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.