Neighborhood Health Plan OF RHODE ISLAND™

Prolia Authorization form
J0897

Tel. 401-427-8200; Fax 844-639-7906

Prolia (denosumab) Prior Authorization form (Drugs Administered in Office), fax requests to 844-639-7906

Please complete the form by providing all of the following information. Failure to fill out this form in its entirety may delay the review process. To review the Clinical Medical Policies, please visit our website at https://www.nhpri.org/Providers/ClinicalMedicalPolicies.aspx

MEMBER INFORMATION		
Member's Name:	Member's ID #:	Member's DOB:
Member Phone Number:	Member Address:	Gender: □ Male □Female □Unknown Primary Language: □ English □Spanish □ Other:
REQUESTING PROVIDER INFORMATION		
Provider's Name:	Provider's Phone #:	Provider's Fax #:
Date of Request:	Provider's NPI #:	Provider's Contact Name and Phone:

SERVICING PROVIDER INFORMATION (Must be filled out appropriately to ensure claim adjudication)

HOW WILL MEDICATION BE OBTAINED:

❑ Drop Ship from Specialty Pharmacy: _____and NPI_____

❑ If Buy & Bill: Specify Provider/ Facility: _____ and NPI _____

Servicing Provider Fax#: _____

CLINICAL INFORMATION		
Requested J-Code:	Requested CPT code(s):	□ Initial Request □ Continuation of therapy Request
Drug Name& strength:		Date(s) of Service Requested:
Directions:		# of units:
ICD 10 Codes:		

Clinical Assessment (provide all required information and clinical documents)	YES	NO
Is Prolia (denosumab) being used for the treatment of osteoporosis in postmenopausal women at high risk for fracture?	☐	☐
Is Prolia (denosumab) being used for treatment of bone loss in women receiving aromatase inhibitor therapy for breast cancer?	☐	☐
Is Prolia (denosumab) being used for the treatment of bone loss in men receiving androgen deprivation therapy for non-metastatic prostate cancer?	☐	☐
Patient has had an inadequate response to alendronate and ibandronate as evidenced by a T score of under -2.0 (please include clinical documentation)	☐	☐
Does the patient have a documented intolerance or contraindication to both alendronate and ibandronate?	☐	☐

NOTE: THIS FORM MUST BE SIGNED BY A PHYSICIAN

Signature of Requesting Provider:	**Date:**

Authorization is not a guarantee of payment. Member must be eligible at time of service.