pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

INJECTABLE BONE RESORPTION SUPPRESSION AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Bone Resorption Suppression Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred injectable medication requested:

- ☐Boniva injection
- ☐Forteo injection → **use Forteo/Tymlos Form**
- ☐ibandronate injection syringe
- ☐ibandronate injection vial
- ☐Miacalcin injection
- ☐Prolia injection
- ☐Reclast 5mg injection
- ☐Tymlos injection → **use Forteo/Tymlos Form**
- ☐Xgeva injection
- ☐zoledronic acid 5 mg bag
- ☐Zometa 4 mg injection vial
- ☐Zometa 4 mg piggyback bottle
- ☐_____________________

Directions:	Quantity:	Refills:
Diagnosis (*submit documentation*):	Dx code (*required*):	

All requests EXCEPT Xgeva

1. Does the beneficiary have results of a recent bone mineral density test (BMD)?
   ☐Yes – *Submit documentation of BMD test results.*
   ☐No

2. Do any of the following apply to the beneficiary? *Check all that apply.*
   ☐history of low-trauma spine or hip fracture or other fragility fracture
   ☐10-year probability of hip fracture ≥ 3% based on the US-adapted WHO algorithm
   ☐10-yr probability of major fracture related to osteoporosis ≥ 20% based on the US-adapted WHO algorithm
   ☐Yes ☐No *Submit all supporting documentation.*

3. Was the beneficiary evaluated for other possible causes of osteoporosis, including the following laboratory tests? *Check all that apply.*
   ☐CBC ☐Vitamin D ☐ionized calcium ☐phosphorous
   ☐albumin ☐total protein ☐creatinine ☐liver enzymes/LFTs
   ☐thyroid stimulating hormone (TSH) ☐urinary calcium excretion ☐intact parathyroid hormone (PTH) ☐testosterone (if male)
   ☐Yes ☐No *Submit results of all requested lab tests.*

4. Does the beneficiary have a history of trial and failure, contraindication, or intolerance to the following agents? *Check all that apply.*
   ☐oral bisphosphonates ☐pamidronate IV
   ☐zoledronic acid 4 mg injection ☐zoledronic acid 5 mg bottle
   ☐Yes ☐No. *Submit documentation of trial and failure, intolerance, or contraindications*

Xgeva requests

1. Does the beneficiary have a diagnosis of giant cell tumor of the bone*? (*NOTE: Giant cell tumor of bone is a benign tumor that typically occurs in young adults between the ages of 20 and 40. It generally occurs at the ends of the body's long bones, most often the lower end of the femur or upper end of the tibia.)
   ☐Yes ☐No *Submit documentation.*

2. ***For diagnoses OTHER THAN giant cell tumor of the bone***, does the beneficiary have a history of trial and failure, contraindication, or intolerance to the preferred agent, zoledronic acid 4 mg injection (*generic Zometa*)?
   ☐Yes – *Submit all supporting documentation.*
   ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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