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

- To review the prior authorization guidelines for Injectable Bone Resorption Suppression Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Bone Resorption Suppression Agents** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to **Quantity Limits / Daily Dose Limits** at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		**PRESCRIBER INFORMATION**	
☐New request ☐Additional info ☐Renewal request (PA# _____)	# of pages in request: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/State/Zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred injectable medication requested	☐Boniva injection ☐Forteo injection* **(*please use "Forteo Form")** ☐ibandronate injection	☐Miacalcin injection ☐Prolia injection ☐Reclast 5mg injection	☐Xgeva injection ☐zoledronic acid 5 mg injection ☐Zometa 4 mg injection

Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:	Dx code (*required*):	
1. Does the Recipient have results of a recent bone mineral density test (BMD)?	☐Yes – *submit documentation of BMD test results* ☐No	
2. Based on the US-adapted World Health Organization (WHO) algorithm, does one of the following apply to the Recipient? ☐10-year probability of hip fracture ≥ 3% ☐10-year probability of major fracture related to osteoporosis ≥ 20%	☐Yes – *submit all supporting documentation* ☐No	
3. Was the Recipient evaluated for other possible causes of osteoporosis, including the following laboratory tests? *Check all that apply.* ☐CBC ☐albumin ☐thyroid stimulating hormone (TSH) ☐Vitamin D ☐total protein ☐urinary calcium excretion ☐ionized calcium ☐creatinine ☐intact parathyroid hormone (PTH) ☐phosphorous ☐liver enzymes/LFTs ☐testosterone (if male)	☐Yes – *submit results of all requested lab tests* ☐No	
4. Does the Recipient have a history of trial and failure, contraindication, or intolerance to the following agents? *Check all that apply.* ☐Actonel tablet ☐Boniva tablet ☐pamidronate IV ☐alendronate tablet ☐Fosamax tablet ☐risedronate tablet ☐alendronate oral solution ☐Fosamax Plus D tablet ☐risedronate DR tablet ☐Atelvia DR tablet ☐ibandronate tablet ☐zoledronic acid 4 mg injection ☐Binosto tablet	☐Yes – *submit all supporting documentation of trial and failure, intolerance, or contraindications* ☐No	
5. *For Xgeva* requests, does the Recipient have a history of trial and failure, contraindication, or intolerance to the preferred injectable agent, zoledronic acid 4 mg injection (*generic Zometa*)?	☐Yes – *submit all supporting documentation of trial and failure, intolerance, and contraindications* ☐No	
6. Injectable Bone Resorption Suppression Agents are part of the Department's Specialty Pharmacy Drug Program (SPDP). What Specialty Pharmacy will be used? Refer to the Department's SPDP website for more information: http://www.dhs.pa.gov/provider/pharmacyservices/thespecialtypharmacydrugprogram/index.htm.	☐Diplomat Specialty Pharmacy ☐Walgreens Specialty Pharmacy	

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

Prescriber Signature:	**Date**: