45 Earhart Drive, Suite 110, Amherst, NY 14221

PROLIA AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Last Name	First Name	Today's Date	Date Needed
Parent/Guardian		Prescriber	Hospital/Clinic
Home Phone Number ( )	Work Phone Number ( )	Phone Number ( )	Fax Number ( )
Home Address	City State Zip	Address	City State Zip
Ship To: ☐ Prescriber ☐ Patient's Home		Office Contact	Prescriber Speciality
Language Preference ☐ English ☐ Spanish ☐ Other			
Known Allergies:		Contact Preference ☐ Phone ☐ Fax ☐ Email: ______	
Weight _______ Lbs.	Height ____ Ft _____ In / Date of Birth ____ / ___ / ____ / Sex ☐ M ☐ F	Special Instructions	

INSURANCE INFORMATION

Fill out entirely or fax a copy of patient's insurance card (both sides):

Primary Insurance: ____________________
Name of Insured: ____________________
Policy #: ____________________
Group #: ____________________
Phone #: ____________________
Rx Drug Card #: ____________________

Secondary Insurance: ____________________
Name of Insured: ____________________
Policy #: ____________________
Group #: ____________________
Phone #: ____________________
Rx Drug Card #: ____________________

PROLIA

☐New Authorization ☐Re-authorization*

For re-authorization:
Updated BMD-T ____________________
Updated Ca+ level ____________________

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: ____________________

ICD9 Code: ____________________

Est. length of therapy: ____________________

Is patient postmenopausal? ☐Yes ☐No

Is BMD-T score less than or equal to -2.5 at spine or total hip? ☐Yes ☐No

Is patient at high risk for fractures as evidenced by osteoporotic fracture, or at least two of the following? ☐Yes ☐No
- ☐ History of frequent falls
- ☐ Limited movement, such as using a wheelchair
- ☐ Medical conditions likely to cause bone loss (i.e., Rheumatoid Arthritis)

Is patient utilizing concurrent medications that may cause bone loss or increase patient risk for falls (i.e., Prednisone or Narcotic Pain Relievers)? ☐Yes ☐No

Current serum Ca+ level: ____________________

Has patient been instructed on use of calcium and Vitamin D supplements? ☐Yes ☐No

Has patient been instructed on symptoms of Hypocalcemia? ☐Yes ☐No

Has patient demonstrated one of the following:
- ☐Tried and failed Alendronate therapy
- ☐Has an established esophageal diagnosis or inability to swallow

Has patient demonstrated one of the following:
- ☐Tried and failed to respond to Reclast as evidenced by disease progression
- ☐Documented contraindication to Reclast

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