BlueCross BlueShield Nebraska

OSTEOPOROSIS TREATMENT
POLICIES X.19 X.97, X.136
PREAUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form for prospective reviews.
The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit NebraskaBlue.com. *Start saving time by filling out this preauthorization form electronically at* MedicalPolicy.NebraskaBlue.com.

What is the priority level of this request?

☐ Standard review - Completed within 15 calendar days of receipt.

☐ Expedited/Urgent review - If the standard time period for a decision could seriously jeopardize the life or health of patient could not be adequately managed; completed within 72 hours of receipt.

Today's Date: _____

Patient and Insurance Information

Patient First Name:	Patient Last Name:	Middle Initial:	Date of Birth (mm/dd/yyyy):
Patient Address:	City, State, ZIP	Member ID Number:	

Prescriber Information

Prescriber Name:	Prescriber NPI:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, ZIP:	Clinic Phone Number:	Secure Fax Number:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Requested product: ☐ Prolia ☐ Evenity ☐ Tymlos ☐ Forteo

Dose requested: _____

Diagnosis for use: _____

1. Is the patient diagnosed with non-metastatic, hormone-sensitive prostate cancer? ☐Yes ☐No
2. Is the patient currently receiving androgen deprivation therapy or adjuvant aromatase inhibitor therapy? ☐Yes ☐No
3. Has the patient had an osteoporosis-related fracture? ☐Yes ☐No
4. Does the patient have history of fragility fracture? ☐Yes ☐No
5. Most recent T-scores: Date obtained: _____
   Femoral Neck: _____ Lumbar: _____ Other: _____
6. Calculated FRAX Scores:
   10yr risk of hip fracture: _____ 10yr risk of major osteoporosis-related fracture: _____

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7. Does the patient have uncorrectable hypocalcemia? ☐Yes ☐No

8. Does the patient have contraindication or intolerance to bisphosphonate therapy? ☐Yes ☐No

If yes, please list bisphosphonates trialed or contraindication: _____

_____

9. Additional medications tried: _____

_____

_____

10. Is the patient currently treated with the requested medication? ☐Yes ☐No

If yes, is the patient at risk if they change therapy? ☐Yes ☐No

11. Additional clinical information: _____

_____

_____

Please fax or mail this form to:
Blue Cross and Blue Shield of Nebraska
Pharmacy Department - UM
PO Box 3248
Omaha, NE 68180-0001

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Phone: 877-999-2374