# MEDICAL PRECERTIFICATION REQUEST FORM

Humana®

**EOC ID:**
Prolia (denosumab) injection 56
**Phone: 1-866-461-7273 Fax back to: 1-888-447-3430**

Humana manages the pharmacy drug benefit for your patient. Certain requests for precertification may require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. **Information left blank or illegible may delay the review process.**

| **Patient name:** | **Prescriber name:** | |
|---|---|---|
| Member/subscriber number: | Fax: | Phone: |
| Patient date of birth: | Office contact: | |
| Group number: | Tax ID: | NPI: |
| Address: | Address: | |
| City, state, ZIP: | City, state, ZIP: | |
| | Specialty/facility name (if applicable): | |

If the patient is a Medicare private-fee-for-service patient, which of the following applies?

I am giving notification. Yes____ No____

I am requesting an advanced coverage determination. Yes____ No____

☐ By checking this box, I am requesting multiple drug reviews for this patient.

**Expedited/exigent/urgent**

☐ By checking this box, I certify an expedited/exigent/urgent review is required. The patient has a health condition that may seriously jeopardize his/her life or ability to regain maximum function**. (Please include explanation of exigency in the space below.)**

| | |
|---|---|
| Drug name and strength: | Dose per infusion/injection: |
| Directions/SIG: | Number of infusions/injections: |
| Quantity/units: | Number of cycles/frequency: |

**Is this a request for services already provided? Yes ___ No ___**

**If yes, please provide date of service: __/__/____**

(Note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

**Please attach pertinent medical history or information for this patient that may support approval and sign this form.**

| |
|---|
| Q1. Please provide diagnosis: * |
| Q2. Please provide J-Code, if applicable: |
| Q3. Please provide ICD Diagnostic Codes: |
| Q4. Is the drug requested part of a clinical trial?<br>☐ Yes ☐ No |

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Q5. If yes, please provide the registration or identification number for the specific trial for which this drug is being studied (e.g. ClinicalTrials.gov Identifier: CT12345678):_____ *

Q6. Please indicate where the drug is being dispensed: *

- ☐ Pharmacy dispensed to patient
- ☐ Pharmacy shipped to prescriber
- ☐ Prescriber dispensed
- ☐ Other

Q7. If other, please specify: *

Q8. Please indicate if this request is a: *

☐ New start/ initial request ☐ Continuation/ Reauthorization request

Q9. For reauthorization requests do medical records demonstrate a stable or increasing BMD (bone mineral density) after a minimum trial of one year? *

☐ Yes ☐ No

Q10. Is the request for the treatment of one of the following: (Please mark all that apply) *

- ☐ Increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer
- ☐ Increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer
- ☐ Treatment of glucocorticoid-induced osteoporosis in men and women at high risk for fracture
- ☐ None of the above

Q11. Is the request for the treatment of osteoporosis for a patient at high risk for fracture (includes men and postmenopausal women)? *

☐ Yes ☐ No

Q12. Does the patient have a diagnosis of osteoporosis with a DXA hip (femoral neck) or spine T-score less than or equal to -2.5 within the past year? *

☐ Yes ☐ No

Q13. Does the patient have a history of a fracture of the spine or hip? *

☐ Yes ☐ No

Q14. Does the patient have a history of T-score between -1 and -2.5 with FRAX (WHO Fracture Risk Assessment Tool) major osteoporotic fracture probability greater than or equal to 20% or hip fracture probability is 3%? *

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☐ Yes ☐ No

Q15. Has the patient had a 12 month minimum trial (e.g. lack of desired improvement in BMD or recurring fractures) with Reclast (zoledronate)? *

☐ Yes ☐ No

Q16. Has the patient had an adverse reaction, intolerance, or contraindication to bisphosphonate(s)? *

☐ Yes ☐ No

Q17. Additional Comments: *

Prescriber signature

Date