Maryland Medicaid Pharmacy Program
Fax: (866) 440-9345
Phone: (800) 932-3918

Prolia® or Forteo®
Prior Authorization Form

Patient's Information: DATE: _____

NAME: DOB:

Recipient's Maryland Medicaid Number: SEX: ❑ M ❑ F

Prescriber's Information:

NAME: NPI #

Phone # Fax #

Contact Person for this Request:

NAME: Phone: Fax:

Y	N	FORTEO®
❑	❑	Does the patient have a diagnosis of primary or hypogonadal osteoporosis in men OR postmenopausal osteoporosis in women?
❑	❑	Does the patient have a diagnosis of glucocorticoid-induced osteoporosis with daily use of > prednisone 5mg daily (or equivalent) for at least 3 months?
❑	❑	Does the patient have any of the following contraindications/exclusions to Forteo® therapy? (Paget's disease, prior external beam or implant radiation therapy involving the skeleton, bone metastases, skeletal malignancies, metabolic bone diseases other than osteoporosis, hypercalcemia or unexplained elevations in alkaline phosphatase)
❑	❑	Has the patient experienced treatment failure with bisphosphonates (i.e. alendronate, etidronate, ibandronate, risendronate)?
❑	❑	Is the use of bisphosphonate therapy contraindicated?
❑	❑	Is the patient receiving at a minimum both calcium 1000 mg and vitamin D 400 IU daily?
❑	❑	Is the request for more than 20 mcg per day?
❑	❑	The duration of treatment will be/is no longer than 2 years during a patient's lifetime.

Directions for use:

Y	N	PROLIA®
❑	❑	Has the patient experienced treatment failure with bisphosphonates (i.e. alendronate, etidronate, ibandronate, risendronate)?
❑	❑	Is the use of bisphosphonate therapy contraindicated?
❑	❑	Does the patient have a diagnosis of breast cancer?
❑	❑	Is the patient receiving an Aromatase Inhibitor Therapy (anastrozole, exemestane, letrozole)?
❑	❑	Does the patient have a diagnosis of non-metastatic prostate cancer?
❑	❑	Is the patient receiving an Androgen Deprivation Therapy (leuprolide, goserelin, triptorelin, histrelin, degarelix, abiraterone, flutamide, bicalutamide, nilutamide, ketoconazole, enzalutamide, etc.)?
❑	❑	Does the patient have any contraindications to Prolia® therapy (hypocalcaemia, pregnancy, hypersensitivity to components)?
❑	❑	Is the patient receiving at a minimum both calcium 1000 mg and vitamin D 400 IU daily?
❑	❑	Is the request for more than one 60 mg/ml injection per 6 months?
❑	❑	Has the patient had 6 or more paid claims for Prolia®?

Directions for use:

I certify that the above information is accurate and will be made available for audit, if requested.

Prescriber's Signature_____ Date_____

Fax this completed form to 866-440-9345. Incomplete forms will not be reviewed.