



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

Visit go.covermymeds.com/OptumRx to begin using this free service.

Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Prolia® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)	Provider Information (required)
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Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)

Continuation of therapy:
 Is this a continuation of prior therapy? Yes No
 If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: **(REQUIRED)**

Select the diagnosis below:

- Increase of bone mass in men with osteoporosis
- Bone loss in men receiving androgen deprivation therapy for prostate cancer
- Bone loss in women receiving adjuvant aromatase inhibitor therapy for breast cancer
- Postmenopausal women with osteoporosis at high risk of fracture
- Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:
 Is there presence of contraindications or absolute drug interactions with existing therapy? Yes No
 Select if there are chart notes or documentation of the following:
 BMD T-score: _____
 10 year fracture risk of hip (greater than or equal to 3 %) or major-osteoporosis related fracture (greater than or equal to 20 %)

Will the prescriber provide a statement or chart notes showing the patient has failure, contraindication, or intolerance to two of the following: risedronate, alendronate, or ibandronate? Yes No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
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