



Fax Referral To: 800-323-2445
Phone: 866-278-6634

**Prolia (denosumab)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members**

Date: _____ Needs by Date (Please Specify): _____

Ship to: Patient Office Other: _____

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (Please copy and attach the front and back of insurance and prescription drug card)

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: Blue Cross Blue Shield of RI Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): 733.0 Osteoporosis Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas that are not filled out will be considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has a diagnosis of osteoporosis in postmenopausal women Yes No
- Patient has a diagnosis of breast cancer Yes No
 - If yes, is the patient receiving adjuvant aromatase inhibitor therapy? Yes No
- Patient has a diagnosis of nonmetastatic prostate cancer Yes No
 - If yes, is the patient receiving androgen deprivation therapy? Yes No
- Patient has uncorrected hypocalcemia Yes No
- Patient's vitamin D status has been evaluated and corrected prior to therapy Yes No
- Patient will receive adequate intake of supplemental calcium and vitamin D Yes No
- Patient is intolerant of at least 2 bisphosphonates (eg, Actonel, Fosamax, Reclast) Yes No
- Patient has a history of severe malabsorption making the use of oral bisphosphonates ineffective Yes No
- Patient has a diagnosis of esophageal stricture, achalasia or other severe esophageal dysmotility condition Yes No
- Patient has inability to stand or sit upright for 60 minutes Yes No
- Patient has renal impairment with CrCL < 35 mL/min Yes No
- Did the patient have an inadequate response to at least 1 bisphosphonate? Yes No
- If yes, please answer the following:
 - Did the patient experience an osteoporosis-related fracture while on a bisphosphonate for at least 1 year? Yes No
 - Did the patient experience a significant decline in BMD while on a bisphosphonate for at least 1 year? Yes No
 - Was the patient compliant with bisphosphonate therapy? Yes No
 - Did the patient receive adequate calcium and vitamin D supplementation while on a bisphosphonate? Yes No

Note: Gastroesophageal reflux (GERD) and dyspepsia diagnoses are not approvable in the absence of the other documented conditions or an intolerance to oral bisphosphonates as presented above.

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Prolia (denosumab)				

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN