

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 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.

Patient Information

Today's Date: _____

Patient Name:	DOB (mm/dd/yyyy):
---------------	-------------------

Insurance Information

BCBS ID Number:

Physician/Clinic Information

Prescriber Name:	Specialty:	
Clinic Name and Address:		
Clinic City, State, Zip Code:	Phone Number:	Secure Fax Number:

Please Note: If approved, a maximum of one 60mg injection is authorized per 180 days.

Preauthorization Information

Initial Authorization

- Patient's diagnosis to be treated with requested medication (ICD 10 code): _____
 - Is the patient diagnosed with non-metastatic, hormone-sensitive prostate cancer or hormone receptor-positive non-metastatic breast cancer?..... ☐Yes ☐No
 - Is the patient currently receiving androgen deprivation therapy or adjuvant aromatase inhibitor therapy?..... ☐Yes ☐No

Provide medication being used from question 1B: _____

- Patient's most recent T-score: _____ Date: _____

For postmenopausal osteoporosis, please answer the following:

- Has the patient had an osteoporosis-related fracture?..... ☐Yes ☐No
- Patient's 10-year hip fracture probability based on FRAX fracture risk model: _____
- Patient's 10-year major osteoporosis-related fracture probability based on FRAX fracture risk model: _____
- Does the patient have a contraindication to or is unable to tolerate bisphosphonate therapy?..... ☐Yes ☐No
If yes, please explain: _____
- Does the patient have uncorrectable hypocalcemia?..... ☐Yes ☐No
Please provide any additional information that should be considered when reviewing this request: _____

Please fax or mail this form to:

Prime Therapeutics
Pharmacy Department - UM
PO Box 3248
Omaha, NE 68180-0001

Toll Free Fax: 877-232-6726

Phone: 877-999-2374

CONFIDENTIALITY NOTE: The information contained in this facsimile message is privileged and confidential information intended only for the use of the individual or entity named above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please immediately notify us by phone, and return the original message to us at the mailing address to the left.