Commonwealth of Massachusetts
MassHealth Drug Utilization Review Program
P.O. Box 2586, Worcester, MA 01613-2586
Fax: 1-877-208-7428 **Phone:** 1-800-745-7318

Print Clear

Osteoporosis Agents and Calcium Regulators Prior Authorization Request

MassHealth reviews requests for prior authorization (PA) on the basis of medical necessity only. If MassHealth approves the request, payment is still subject to all general conditions of MassHealth, including current member eligibility, other insurance, and program restrictions. MassHealth will notify the requesting provider and member of its decision. Keep a copy of this form for your records. If faxing this form, please use black ink.

Additional information about these agents, including PA requirements and preferred products, can be found within the MassHealth Drug List at **www.mass.gov/druglist.**

Member information

Last name _____ First name _____ MI _____

MassHealth member ID # _____ Date of birth _____

Gender (Check one.) ☐ F ☐ M Member's place of residence ☐ home ☐ nursing facility

Medication information

Bisphosphonates

☐ alendronate solution (Section V)
☐ Binosto (alendronate effervescent tablet) (Section V)
☐ Fosamax Plus D (alendronate/cholecalciferol) (Section VI)
☐ ibandronate IV (Section I)
☐ ibandronate tablet (Section I)
☐ risedronate (Section I)
☐ risedronate delayed-release (Section I)
☐ zoledronic acid 5 mg (Section I)

Miscellaneous Agents

☐ Forteo (teriparatide) (Section III)
☐ Miacalcin (calcitonin salmon injection) (Section III)
☐ Natpara (parathyroid hormone) (Section IV)
☐ Prolia (denosumab) (Section I)
☐ Tymlos (abaloparatide) (Section III)
☐ Xgeva (denosumab) (Section VII and VIII)

Dose and frequency of medication requested

Dose _____ Frequency _____

Indication (Check all that apply.)

☐ Giant cell tumor of the bone (Xgeva) (Section VIII)
☐ Glucocorticoid-Induced Osteoporosis (GIO) (Section II)
☐ Hypercalcemia
☐ Hypercalcemia of malignancy (Xgeva) (Section VII)
☐ Hypocalcemia with hypoparathyroidism
☐ Osteopenia
☐ Paget's Disease
☐ Post Menopausal Osteoporosis (PMO)
☐ Prevention of bone loss in men receiving androgen deprivation therapy for prostate cancer
☐ Prevention of bone loss in women receiving aromatase inhibitors for breast cancer
☐ Prevention of skeletal-related events secondary to bone metastases in cancer related to solid tumors and in multiple myeloma (Xgeva) (Section VII)
☐ Primary/Hypogonadal Osteoporosis
☐ Other _____

Section I. Please complete for bisphosphonates and Prolia as indicated above. For zoledronic acid 5 mg requests for a diagnosis of Paget's disease, complete questions 1 through 3 only.

1. Please provide results of bone mineral density (BMD) measurements (T-scores of total hip and lumbar vertebrae).

   _____

2. Has the member had a radiographically confirmed fracture?
   ☐ Yes. Please provide site and date below.
   Site _____ Date _____
   ☐ No.
3. Please list all non-modifiable risk factors for fracture in this member.

   _____

4. Has the member tried alendronate and experienced an adverse reaction or inadequate response?
   ☐ Yes. Please list the dates/duration of alendronate trial and outcomes in Section IX below.*
   ☐ No. Please document if there is a contraindication to oral bisphosphonates.

   _____

5. Has the member tried other medications for the treatment of this condition?
   ☐ Yes. Please list the drug names, dates/duration of trials and outcomes in Section IX below.*
   ☐ No. Please explain why not. _____

   _____

Section II. Please complete for all agents being requested for the treatment or prevention of Glucocorticoid-Induced Osteoporosis (GIO).

Please provide specifics of the member's chronic glucocorticoid use.
Drug _____ Dose and Frequency _____ Dates/Duration _____

Section III. Please complete for Forteo, Miacalcin injection, and Tymlos requests.

Please attach supporting documentation of the diagnosis, BMD measurements, medical necessity for the requested agent, and previous trials including alendronate, IV bisphosphonates (ibandronate, pamidronate, zoledronic acid 5 mg), or Prolia as applicable.

Section IV. Please complete for Natpara requests.

Please attach supporting documentation of diagnosis and previous trials including calcium and active vitamin D supplementation as applicable. Please also attach consultation notes from an endocrinologist addressing the use of the requested agent.

Section V. Please complete for alendronate solution and Binosto requests.

Please provide compelling clinical rationale for the use of oral solution/orally disintegrating tablets instead of alendronate tablets.

_____

_____

Section VI. Please complete for Fosamax Plus D requests.

Please provide compelling clinical rationale for why the combination alendronate/cholecalciferol would offer a therapeutic advantage over the individual agents.

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Section VII. Please complete for Xgeva requests for a diagnosis of prevention of skeletal-related events secondary to bone metastases in cancer related to solid tumors and multiple myeloma, and hypercalcemia of malignancy.

Has the member tried pamidronate or zoledronic acid 4 mg and experienced an adverse reaction or inadequate response?

☐ Yes. Please list the drug names, dates/duration of trials and outcomes in Section IX below.*

☐ No. Please document if there is a contraindication to IV bisphosphonates. _____

_____

Section VIII. Please complete for Xgeva requests for a diagnosis of giant cell tumor of the bone.

Please describe surgical history and/or prognosis. If surgery is not appropriate for this member, please explain.

_____

_____

Section IX. Please complete for all requests as needed. *Please provide the following information regarding previous trials.**

Drug name/Therapy _____ Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response.

_____

Drug name/Therapy _____ Dates/duration of use _____

Did the member experience any of the following? ☐ Adverse reaction ☐ Inadequate response

Briefly describe details of adverse reaction or inadequate response.

_____

** Please attach a letter documenting additional trials as necessary*.

Section X. Please complete for all requests for non-preferred drug products if one or more preferred drug products have been designated for this class of drugs.

If one or more preferred drug products have been designated for this class of drugs, and if you are requesting PA for a non-preferred drug product, please provide medical necessity for prescribing the non-preferred drug product rather than the preferred drug product.

_____

_____

Prescriber information

Last name* _____ First name* _____ MI _____

NPI* _____ Individual MH Provider ID _____

DEA No. _____ Office Contact Name _____

Address _____ City _____ State _____ Zip _____

E-mail address _____

Telephone No.* _____ Fax No.* _____

* *Required*

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Prescribing provider's attestation, signature, and date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in the Prescriber information section of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the provider, are not acceptable.)

Signature required _____

Printed name of prescribing provider _____ Date _____