

To submit request electronically, please go to providerportal.surescripts.net/ProviderPortal/login OR covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: [888-446-8535](tel:888-446-8535)

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 2251, Durham, NC 27702-2251

Call: [888-298-7552](tel:888-298-7552) Blue Medicare Rx
[888-296-9790](tel:888-296-9790) Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information		Patient Information	
Physician Name:		NPI #:	
Office Contact Person:		Patient Name:	
Office Phone #:		Patient ID #:	
Office Fax #:		Home Phone #:	
Address:		Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	
City:	State:	Zip:	DOB:
Diagnosis and Medication Information			
Medication Requested:		Diagnosis Code:	
Strength and Route of Administration:		Dosing Schedule:	
Quantity per 30 Days:			
Please answer questions below			
1. Is this request for an expedited review?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy. A standard review will have a decision made within 72 hours for a coverage determination.</i>			
2. Please select the diagnosis for the requested medication and answer any associated questions:			
<input type="checkbox"/> Osteoporosis (male or postmenopausal female)			
A. Does the patient have a fragility fracture in the hip or spine?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
B. Does the patient have a T-score of -2.5 or lower?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
C. Does the patient have a T-score of -1.0 to -2.5?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
i. If YES , does the patient have a fragility fracture of the proximal humerus, pelvis, or distal forearm? <input type="checkbox"/> Yes <input type="checkbox"/> No			
ii. Does the patient have a FRAX 10-year probability for major osteoporotic fracture of 20% or greater or probability of hip fracture of 3% or greater? <input type="checkbox"/> Yes <input type="checkbox"/> No			
D. Does the patient have any of the following?:			
i. A medication history that includes the use of a bisphosphonate OR an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
ii. A recent fracture (within the past 12 months)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
iii. A history of fractures while on FDA approved osteoporosis therapy?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
iv. A history of multiple fractures?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
v. A history of fractures while on medications causing skeletal harm (e.g., long-term glucocorticoids)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
vi. A very low T-score (less than -3.0)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
vii. A high risk for falls or a history of injurious falls?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
viii. A very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm?..... <input type="checkbox"/> Yes <input type="checkbox"/> No			
PLEASE CONTINUE TO NEXT PAGE			

Osteopenia (osteoporosis prophylaxis)

- A. Is the patient either a male who is at least 50 years of age OR a postmenopausal female?..... Yes No
- B. Does the patient have a T-score between -1.0 to -2.5?..... Yes No
- C. Does the patient have a fragility fracture of the proximal humerus, pelvis, or distal forearm?..... Yes No
- D. Does the patient have a FRAX 10-year probability for major osteoporotic fracture of 20% or greater or probability of hip fracture of 3% or greater?..... Yes No
- E. Does the patient have a medication history that includes the use of a bisphosphonate OR an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate?..... Yes No

Breast cancer

- A. Is the patient's sex female?..... Yes No
- B. Is the patient receiving aromatase inhibitor therapy?..... Yes No
- C. Does the patient have a medication history that includes the use of a bisphosphonate OR an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate?..... Yes No

Prostate cancer

- A. Is the patient receiving androgen deprivation therapy (ADT)?..... Yes No
- B. Does the patient have a medication history that includes the use of a bisphosphonate OR an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate?..... Yes No

Glucocorticoid-induced osteoporosis

- A. Is the patient either initiating or continuing systemic glucocorticoids in a daily dose equivalent to 7.5 mg or greater of prednisone?..... Yes No
- B. Is the patient expected to remain on glucocorticoids for at least 6 months?..... Yes No
- C. Does the patient have a fragility fracture in the hip or spine?..... Yes No
- D. Does the patient have a T-score of -2.5 or lower?..... Yes No
- E. Does the patient have a T-score of -1.0 to -2.5?..... Yes No
 - i. **If YES**, does the patient have a fragility fracture of the proximal humerus, pelvis, or distal forearm? Yes No
 - ii. Does the patient have a FRAX 10-year probability for major osteoporotic fracture of 20% or greater or probability of hip fracture of 3% or greater? Yes No
- F. Does the patient have any of the following?:
 - i. A medication history that includes the use of a bisphosphonate OR an intolerance, FDA labeled contraindication, or hypersensitivity to a bisphosphonate?..... Yes No
 - ii. A recent fracture (within the past 12 months)?..... Yes No
 - iii. A history of fractures while on FDA approved osteoporosis therapy?..... Yes No
 - iv. A history of multiple fractures?..... Yes No
 - v. A history of fractures while on medications causing skeletal harm (e.g., long-term glucocorticoids)?..... Yes No
 - vi. A very low T-score (less than -3.0)?..... Yes No
 - vii. A high risk for falls or a history of injurious falls?..... Yes No
 - viii. A very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5%) or by other validated fracture risk algorithm?..... Yes No

Other (please specify): _____

3. Are pretreatment or current calcium levels available?..... Yes No
- A. **If YES**, is the patient hypocalcemic?..... Yes No
 - i. **If YES**, will the calcium levels be corrected prior to use of the requested medication?..... Yes No
 - B. **If NO**, is the patient at risk for hypocalcemia (not including the risk associated with the requested medication)?..... Yes No

PLEASE CONTINUE TO NEXT PAGE

4. Will the patient be using the requested medication in combination with a bisphosphonate, another form of denosumab (e.g., Xgeva), romosozumab-aggg (Evenity), or parathyroid hormone analog [e.g., abloparatide (Tymlos), teriparatide (Forteo)] for the requested indication?..... Yes No
5. Is the patient female?..... Yes No
A. **If YES**, is the patient pregnant?..... Yes No
6. Is the requested dose within FDA labeled dosing or supported in CMS approved compendia dosing for the requested indication?..... Yes No

I certify that I have appropriate authority to request a coverage determination for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature: _____ Date: _____