

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication New or Continuation of Therapy? If continuation, list start date: _____
 Is this patient currently hospitalized? Yes No If recently discharged, list discharge date: _____

Section B - Physician Information

First Name:	Last Name:			M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

- Does the patient have a diagnosis of osteoporosis? Yes No

- What is the patient's BMD T-score based on BMD measurements from lumber spine, hip, or radius? (check which apply)
 - Less than or equal to -3.5
 - Between -2.5 and -3.5 (greater than -3.5 and less than or equal to -2.5)
 - Between -1 and -2.5 (greater than -2.5 and less than or equal to -1)
 - Greater than -1: List score: _____

- Does the patient have a history of any of the following resulting from minimal trauma: Yes No (check all that apply)
 - Vertebral compression fracture
 - Fracture of the hip
 - Fracture of the distal radius
 - Fracture of the pelvis
 - Fracture of the proximal humerus; List: _____
 - Fracture of the pelvis

- Does the patient have a history of failure, contraindication, or intolerance to a conventional osteoporosis therapy? Yes No
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

- Does the patient have either of the following FRAX 10-year probabilities? Yes No (check which apply)
 - Major osteoporotic fracture at 20% or more Hip fracture at 3% or more

- Has the treatment duration exceeded a total of 24 months of cumulative use of parathyroid hormone analogs during the patient's lifetime? Yes No
If no, list how many months patient has already received of parathyroid hormone analogs: _____

Physician Signature: _____ **Date:** _____

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Website: uhcommunityplan.com