CHORUS
COMMUNITY HEALTH PLANS

PROLIA - Prior Authorization Form

Prior Authorization Form for Chorus Community Health Plan Members
If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

PLEASE TYPE OR PRINT NEATLY. ***Incomplete responses may delay this request.***

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Patient Name:	**CCHP Member ID #:**	**Patient DOB:**	**Patient Age:**

Drug Requested: ❑ **Brand** ❑ **Generic**	**Strength:**	**Frequency:**	**Expected length of therapy:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ **New Medication** ❑ **Ongoing Medication**	**If Ongoing Provide Date Started:**	**If medication is ongoing, did the member show improvement while on therapy?**	❑ **Yes** ❑ **No**

Diagnosis:

Please indicate place of administration:	❑ Physician's Office ❑ Hospital/Clinic
Please provide hospital/facility name and address:	

Will the drug be: (select one)
- ❑ Billed directly by the provider via JCODE
  JCODE: _____
- ❑ Billed by a pharmacy and delivered to the provider
- ❑ Billed by a pharmacy and delivered to the patient

MEDICAL HISTORY

Please provide baseline bone mineral density (BMD) T score: _____ Date of test: _____

Please provide current bone mineral density (BMD) T score: _____ Date of test: _____

Please provide BMD skeletal site measured: _____

Does the member have a history of fracture? ❑Yes ❑No

If yes, please indicate fracture site: _____

Please include fracture date: _____

HISTORY OF MEDICATIONS USED TO TREAT THE ABOVE CONDITION

Medication Trial/ Previous Therapies	Date of Therapy Start Date	Date of Therapy End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing

Please provide any additional information which should be considered in the space below: