Prolia® Insurance Verification Request Form

Please complete this form to the fullest extent possible.
If an item does not apply, please note "N/A" on that line.
Fax with insurance card copies to ProliaPlus®: 1-877-877-6542

prolia® (denosumab) injection

Patient Information

Patient Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Telephone: _____
M ❑ F ☒ Date of Birth: _____
Social Security Number: _____

Primary Insurance Information

❑ Attach a copy of insurance card, front AND back
OR Complete insurance information below:
Name of Insurer: _____
Insurer Telephone: _____
Subscriber Date of Birth: _____
Subscriber Relation to Patient: _____
Group Number: _____
Policy Number: _____

Secondary Insurance Information

❑ Attach a copy of insurance card, front AND back
OR Complete insurance information below:
Name of Insurer: _____
Is this a Medigap policy ❑ Yes ❑ No
If yes, please indicate plan letter: ____
Insurer Telephone: _____
Subscriber Name: _____
Subscriber Relation to Patient: _____
Group Number: _____
Policy Number: _____

Pharmacy Insurance Information

❑ Attach a copy of insurance card front AND back **OR** provide:
Pharmacy Insurance Patient ID #: _____
Pharmacy Insurance Telephone #: _____

Preferred Fulfillment Option

Step 1: Select one of the following (leave blank if no preferred option)
❑ Physician Purchase (Buy and Bill)
❑ Injection Network
If preferred location, please list name and phone #: _____
_____
❑ Specialty Pharmacy
If preferred pharmacy, please list name and phone #: _____
_____
❑ Retail Pharmacy
Step 2: ❑ **Check here if you would like Prior Authorization support**

Physician Information

Physician Name: _____
Specialty: _____
Site Name: _____
Site Street Address: _____
City: _____ State: _____ Zip: _____
Telephone: (____) _____ Fax: (____) _____
Email address: _____
Office Contact: _____
Physician Tax ID #: _____
Physician NPI #: _____
Payor Specific Provider #'s for Named Insurance (if applicable):
Primary Insurance: _____
Secondary Insurance: _____
Site Type: ❑ MD Office ❑ Hospital Outpatient ❑ Other _____

Patient Medical Information*

Please provide one primary ICD-9 code:
❑ 733.00 Osteoporosis, unspecified
❑ 733.01 Senile osteoporosis, postmenopausal osteoporosis
❑ Other (specify ICD-9-CM) _____
Please provide secondary ICD-9 code, if applicable:
❑ Other (specify ICD-9-CM) _____
T-Score (if known): _____
History of osteoporotic fracture ❑ Yes ❑ No ❑ Not known
Skeletal Site (if known): _____
Other risk factors for osteoporotic fracture (if any): _____
Prior Treatment History (if any):
❑ Generic alendronate ❑ Fosamax® (alendronate sodium)
❑ Actonel® (risedronate sodium) ❑ Boniva® (ibandronate sodium)
❑ Other _____
Reason for Discontinuing Previous Osteoporosis Therapy(ies):
_____
Contraindications (if any):
_____
Pertinent Medical History (eg, calcium and vitamin D supplementation):
_____

* The sample diagnosis codes are informational and not intended to be directive or a guarantee of reimbursement and include potential codes that would include FDA approved indications for Prolia®. Other codes may be more appropriate given internal system guidelines, payor requirements, practice patterns, and the services rendered.

Prescription Information

Product Name/Strength: Prolia® 60 mg pre-filled syringe
Directions: 60 mg SC every 6 months Refill: _____
State License: _____

Prescriber Signature:

✗ _____ Date: _____

Fax Completed Form and/or Copy of Insurance Card(s) to ProliaPlus®: 1-877-877-6542

Prior to transmittal of any personal health information ("PHI"), obtain the legally-required patient authorizations for verification services

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