Rank Ligand (RANKL) Inhibitors

Please fax this completed form to (833) 645-2734 OR mail to: Centene Pharmacy Services | 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation demonstrating disease stability or a positive clinical response)?
   ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   - ☐ Glucocorticoid-induced osteoporosis
   - ☐ Postmenopausal osteoporosis
   - ☐ Bone loss in men with prostate cancer
   - ☐ Bone loss in women with breast cancer
   - ☐ Bone metastasis from solid tumors
   - ☐ Multiple myeloma with skeletal-related events
   - ☐ Giant cell tumor of bone
   - ☐ Hypercalcemia of malignancy

3. Will the medication be used in combination with other bone density regulators? ☐ Yes ☐ No
   If yes, specify:
   - ☐ bisphosphonates ☐ raloxifene
   - ☐ Prolia (denosumab) ☐ Xgeva (denosumab)

4. Indicate if patient has any of the following:
   - ☐ Presence of fragility fractures of the hip or spine regardless of bone mineral density
   - ☐ T-score ≤ -2.5 in the lumbar spine, femoral neck, total hip
   - ☐ T-score between -1 and -2.5 with a history of recent fragility fracture of proximal humerus, pelvis, or distal forearm
   - ☐ T-score between -1 and -2.5 with a FRAX 10-year probability for major fracture ≥20% or hip fracture ≥3%

5. Has the patient been treated with at least one Apple Health Preferred Drug (oral or intravenous) unless ineffective, contraindicated or not tolerated? Please select all that apply:
   - ☐ Bisphosphonate (minimum trial of 12 months) , specify: _____
   - ☐ Selective estrogen receptor modulator (SERM) (minimum trial of 24 months) , specify: _____
   - ☐ Other, specify: _____
   - ☐ Contraindicated, provide contraindication: _____

For the diagnosis of Glucocorticoid Induced Osteoporosis:

6. Will patient be initiating or continuing systemic glucocorticoid therapy at a daily dosage equivalent to ≥ 7.5 mg of prednisone? ☐ Yes ☐ No
   If yes, is patient expected to remain on glucocorticoid therapy for at least 6 months? ☐ Yes ☐ No

For bone loss in men and prostate cancer:

7. Is patient currently receiving androgen deprivation therapy (ADT) (e.g., leuprolide, degarelix, relugolix) for non-metastatic prostate cancer?
   ☐ Yes
   ☐ No
   ☐ Contraindicated or not tolerated. Explain: _____

For bone loss in women with breast cancer:

8. Will patient be receiving adjuvant aromatase inhibitor therapy (e.g., anastrozole, exemestane, letrozole) for breast cancer?
   ☐ Yes
   ☐ No
   ☐ Contraindicated or not tolerated. Explain: _____

For Multiple Myeloma:

9. Does patient have a history of failure, contraindication, or intolerance to zoledronic acid? ☐ Yes ☐ No
   If contraindicated, provide contraindication: _____

For giant cell tumor of bone:

10. Indicate the following for patient. Check all that apply.
    ☐ Disease is unresectable or surgical resection is likely to result in severe morbidity?
    ☐ Disease recurrent or metastatic

For hypercalcemia of malignancy

11. Does patient have a baseline corrected serum calcium > 12.5 mg/dL? ☐ Yes ☐ No

CHART NOTES ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date

Centene Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)