GHP Family Pharmacy Customer Service
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Geisinger

EVISTA (raloxifene) PRIOR AUTHORIZATION FORM *(form effective 1/1/20)*

Prior authorization guidelines for A Bone Density Regulators and Quantity Limits/Daily Dose Limits are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐ New request ☐ Renewal request	Total # pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Phone number of office contact:		NPI:	State license #:
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:	☐ Evista 60 mg tablet	☐ Raloxifene 60 mg tablet	Directions:
Quantity:	Refills:	Diagnosis:	Dx code (*required*):

Complete the sections below that are applicable to the beneficiary and this request and SUBMIT DOCUMENTATION for each item.

INITIAL requests:

☐ Is a post-menopausal or post-oophorectomy female
☐ Has one or more risk factors for stroke:
- ☐ history of stroke or TIA ☐ hypertension ☐ other:_____
- ☐ atrial fibrillation ☐ cigarette smoker

☐ Has results of a recent bone mineral density test
☐ Has a 10-year probability of hip fracture ≥ 3% based on the US-adapted WHO algorithm
☐ Has a 10-yr probability of major fracture related to osteoporosis ≥ 20% based on the US-adapted WHO algorithm
☐ Was evaluated for other possible causes of osteoporosis and has results of the following lab tests:
- ☐ CBC ☐ phosphorous ☐ total protein ☐ thyroid stimulating hormone (TSH)
- ☐ vitamin D ☐ creatinine ☐ liver enzymes/LFTs ☐ intact parathyroid hormone (PTH)
- ☐ ionized calcium ☐ albumin ☐ urinary calcium excretion ☐ testosterone (if male)

☐ Is at high risk for invasive breast cancer defined by at least one of the following:
- ☐ Prior biopsy with lobular carcinoma in situ (LCIS) or atypical hyperplasia
- ☐ One or more first-degree relatives with breast cancer
- ☐ A 5-year predicted risk of breast cancer ≥ 1.66% (based on the modified Gail model)

☐ Does the beneficiary have a history of trial and failure of (i.e., documented continued bone loss or a fragility fracture after 2 or more years of treatment) or contraindication or intolerance to bisphosphonates (e.g., alendronate, risedronate, zoledronic acid, etc.)?
☐ Does not have a documented history of venous thromboembolic events or breast cancer

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	Date: