

## **MEDICARE FORM**

## Prolia®, Xgeva® (denosumab) Injectable Medication Precertification Request

Page 1 of 3

(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP: FAX: 1-833-322-0034 PHONE: 1-844-362-0934 For other lines of business:

Please use other form.

Note: Xgeva is non-preferred. The preferred products are pamidronate or zoledronic acid. Pamidronate and zoledronic acid do not require precertification.

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<b>Precertification Reques</b>	ted By:					Phone:		Fax	c:	
A. PATIENT INFORMA	TION									
First Name:				Last Name:				DOB:		
Address:					City:			State:	2	ZIP:
Home Phone:		Work Phor	ne:		Cell P	hone:		Email:	•	
Current Weight: lbs	orkgs	s 1	Height: _	inches or	cms	Allergies:		•		
B. INSURANCE INFOR	MATION									
Aetna Member ID #:				Does patient have other coverage?						
Group #:				If yes, provide ID#: Carrier Name:						
Insured:				Insured:						
C. PRESCRIBER INFO	RMATION									
First Name:				Last Name:			(Check one)	: M.D.	☐ D.O.	. N.P. P.A
Address:					City:			State:	2	ZIP:
Phone:	Fax:		St Lic :	#:	NPI#	:	DEA #:		UPIN:	
Provider E-mail:			Office	Contact Name:			Phone:			
D. DISPENSING PROV	IDER/ADMIN	ISTRATION	N INFO	RMATION						
Place of Administration:						ispensing Provider/	-			
Self-administered	-	ician's Offic				Physician's Office		Retail Pha	-	
Outpatient Infusion Center Phone:						☐ Specialty Pharmac	-			
Center Name: _  Home Infusion Center		Phono:				Name:				
Agency Name:		-none			<del></del>   '	Address:				
☐ Administration code(s)					_   '	Phone:		Fax:		
Address:					-	TIN:		NPI:		
E. PRODUCT INFORMA										
E. PRODUCT INFORM	ATION									
Request is for: Pro		Dose: _		Frequenc	y:					
	lia 🗌 Xgeva						н			
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## MEDICARE FORM Prolia®, Xgeva® (denosumab) Injectable Medication Precertification Request

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(All fields must be completed and legible for precertification review.)

For New Jersey HMO D-SNP: FAX: 1-833-322-0034 PHONE: 1-844-362-0934

For other lines of business:

Please use other form.

Note: Xgeva is non-preferred. The preferred products are pamidronate or zoledronic acid. Pamidronate and zoledronic acid do not require precertification.

Patient First Name	Patient Last Name	Patient Phone	Patient DOB
C. CLINICAL INFORMATION (conf	inual Dequired clinical information	n must be completed in its entirety	for all proportification reguests
G. CLINICAL INFORMATION (cont. For Prolia Requests:	<i>inued)</i> – Required clinical informatio	n must be completed in its <u>entirety</u>	viol all precentification requests.
Post-menopausal osteoporosis			
Please select which of the following med	dication(s) was ineffective, not tolerate	d or contraindicated:	
Select all that apply:   Alendronate (B			☐ Ibandronate (Boniva)
			Zoledronic acid (Zometa, Reclast)
☐ Raloxifene (Evi	sta) 🔲 Tamoxifen (Nolvadex/Soltame	ox) Toremifene citrate (Farestor	n)
☐ Other: Please i			
Prevention or treatment of osteoporos		herapy for breast cancer	
Yes No Is the patient receiving			
	of the following endocrine therapy (arc	· · · · · · · · · · · · · · · · · · ·	
	dex)		e identify:
Yes No Is there documentation			
	ure of the medication trial:  Continue		tify:
	ate range: / _ /		
	ate range: /		
Yes No Is there documented ev	•		
Yes No Is there documented ev			
Please select which of the following bisp	•		D. H. and done at a (D. anima)
Select all that apply: Alendronate (B			
	ctonel, Actonel with Calcium or Atelvia dentify:	) 🔲 Zoledronic acid (Zometa, Reci	ast)
Treatment to increase bone mass in n		therapy	
☐ Yes ☐ No Does the patient have p	prostate cancer?		
☐ Yes ☐ No Is the patient receiving	androgen deprivation therapy?		
Treatment of bone loss in men with o	steoporosis		
☐ Yes ☐ No Is there documentation	that the patient had an oral or injectab	le bisphosphonate trial of at least 1-	year duration?
	ure of the medication trial:  Continue		tify:
	ate range: /		
Bisphosphonate #2 Da	ate range: /	<u>/ / / / / / / / / / / / / / / / / / / </u>	
☐ Yes ☐ No Is there documented ev	idence that the patient has an intolera	nce to bisphosphonates?	
☐ Yes ☐ No Is there documented ev	idence that the patient has a contrainc	ication to bisphosphonates?	
Please select which of the following bisp	phosphonates was ineffective, not toler	ated or contraindicated:	
Select all that apply:   Alendronate (B			
	ctonel, Actonel with Calcium or Atelvia	) 🔲 Zoledronic acid (Zometa, Recl	ast)
Other: Please i	,		
Treatment of glucocorticoid-induced			and the second s
or more?	or continuing systemic glucocorticolas a	at a daily dosage equivalent to 2.5 m	ng or greater of prednisone for 3 months
I I	ating systemic glucocorticoids 🔲 con	tinuing systemic alucocorticoids	
	e patient expected to remain on glucoc		
☐ Yes ☐ No Is there documentation			
	ure of the medication trial:   Continue		tifv·
1	ate range:/ _/		,.
Bisphosphonate #2 Da	ate range:/	· · · · · · · · · · · · · · · · · · ·	
☐ Yes ☐ No Is there documented ev			
Yes No Is there documented ev	•		
Please select which of the following bisp	•		
Select all that apply:   Alendronate (B	•		☐ Ibandronate (Boniva)
	ctonel, Actonel with Calcium or Atelvia	, ,	, ,
☐ Other: Please i		,,	,

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## MEDICARE FORM Prolia®, Xgeva® (denosumab) Injectable Medication Precertification Request

Page 3 of 3

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
G. CLINICAL INFORMATION	(continued) - Required clinical information	n must be completed for ALL prec	ertification requests.
For Xgeva Requests:			
Bone metastases from solid tu	imors		
Please indicate which of the follo	owing pertains to the patient: 🔲 Bladder canc	er 🔲 Breast cancer 🔲 Kidney ca	ncer 🔲 Ovarian cancer
	☐ Non-small ce	Il lung cancer ☐ Prostate cancer	☐ Thyroid cancer
	☐ Other: Please	e specify:	
☐ Giant cell tumor of the bon	e		
☐ Prevention of skeletal-relat	ted events in patients with multiple myelom	ıa	
Treatment of hypercalcemia of			
	been treated with intravenous bisphosphonate		
Please indicat	e the date range of therapy://		
	cemia of malignancy refractory to intravenous I	bisphosphonate therapy?	
☐ Yes ☐ No Has the albumir	n-corrected serum calcium level been tested?		
Please provide	e the albumin-corrected serum calcium level: _	mg/dL Date:/	
For Continuation Requests	: (Clinical documentation required for	all requests)	
	at have a hypersensitivity to denosumab?	<u>-</u>	
ı —	ponse the patient has experienced while on de	enosumah: □ No response □ Min	imal response
I reace marcate what type of rec	period the patient had experienced wind on at	☐ Significant improveme	. –
H. ACKNOWLEDGEMENT		_ 3 ;	
Request Completed By (Si	gnature Required):		Date: /
any insurance company by pr		eals material information for the p	with the intent to injure, defraud or deceive urpose of misleading, commits a fraudulent

The plan may request additional information or clarification, if needed, to evaluate requests.