

## Medical prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)**

☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

# Xgeva<sup>®</sup> (denosumab)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Requesting Provider: \_\_\_\_\_ Prov. Phone: \_\_\_\_\_ Prov. Fax: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Product and Billing Information

☐ New Request ☐ Continuation Request

Drug product: ☐ Xgeva 120 mg/1.7 mL vial

Start date (or date of next dose): \_\_\_\_\_

Date of last dose (if applicable): \_\_\_\_\_

Dosing frequency: \_\_\_\_\_

Place of administration: ☐ Physician's office

☐ Outpatient infusion

Facility: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

☐ Home infusion

Agency: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

Billing: ☐ Physician to buy and bill

☐ Facility to buy and bill

☐ Specialty Pharmacy

Pharmacy: \_\_\_\_\_ NPI: \_\_\_\_\_ Fax: \_\_\_\_\_

ICD-10 Diagnosis code(s): \_\_\_\_\_

## Precertification Requirements

**Before this drug is covered, the patient must meet one of the following requirements (please provide supporting documentation):**

1. Giant cell tumor of bone (unresectable or resection may cause severe morbidity)
2. Bone metastases from solid tumors previously treated with zoledronic acid (generic Zometa) unless the patient has bone metastases with advanced breast cancer, prostate cancer, or lung cancer.
3. Multiple myeloma for the prevention of skeletal-related events previously treated with zoledronic acid

**Note:** Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

## Priority Health Precertification Documentation

### A. What condition is this drug being requested for?

- ☐ Giant cell tumor of bone (unresectable or resection may cause severe morbidity)
- ☐ Bone metastases from solid tumors
- ☐ Multiple Myeloma
- ☐ Other – the patient's condition is: \_\_\_\_\_

### B. Has the patient had a trial with zoledronic acid (generic Zometa)?

- ☐ Yes
- ☐ No, the patient has prostate cancer
- ☐ No, the patient has breast cancer
- ☐ No because: \_\_\_\_\_