



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

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

Aetna Precertification Notification  
503 Sunport Lane, Orlando, FL 32809

Phone: 1-866-752-7021

FAX: 1-888-267-3277

For Medicare Advantage Part B:

Phone: 1-866-503-0857

FAX: 1-844-268-7263

Please indicate:  Start of treatment: Start date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Continuation of therapy: Date of last treatment \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Precertification Requested By: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## A. PATIENT INFORMATION

First Name:		Last Name:		DOB:	
Address:		City:		State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:		Email:	
Current Weight: _____ lbs or _____ kgs		Height: _____ inches or _____ cms		Allergies:	

## B. INSURANCE INFORMATION

Aetna Member ID #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____
Medicare: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____	Medicaid: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide ID #: _____

## C. PRESCRIBER INFORMATION

First Name:		Last Name: _____ (Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty (Check one):  Oncologist  Hematologist  Internal Medicine  Primary Care  GYN  Other: \_\_\_\_\_

## D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

<b>Place of Administration:</b> <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Outpatient Infusion Center Phone: _____ Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____	<b>Dispensing Provider/Pharmacy: (Patient selected choice)</b> <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other: _____ Name: _____ Address: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____
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## E. PRODUCT INFORMATION

Request is for:  Prolia  Xgeva Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_

## F. DIAGNOSIS INFORMATION – Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: \_\_\_\_\_ Secondary ICD Code: \_\_\_\_\_ Other ICD Code: \_\_\_\_\_

## G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

**For All Requests: (Clinical documentation required for all requests)**

Please provide the patient's Bone Mineral Density (BMD) score and date obtained: T-score: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Please indicate the location the BMD was measured:  femoral neck  lumbar spine  total hip  other: please identify: \_\_\_\_\_

Yes  No Is the patient receiving 1000mg of calcium and 400 international units of vitamin D daily?

Yes  No Does the patient have clinical evidence of uncorrected preexisting hypocalcemia?

Yes  No Will the patient be using denosumab in combination with intravenous bisphosphonates?

Yes  No Will the patient be using Prolia in combination with Xgeva?

Yes  No Is the patient at high risk for fractures?

Yes  No Has the patient had an osteoporotic fracture?

Yes  No Does the patient have multiple risk factors for fractures?  
Please explain (select all that apply):  alcohol intake of 4 or more units per day  parental history of hip fracture  
 rheumatoid arthritis  current tobacco smoking  none of the above

Yes  No Is the patient pregnant or planning to become pregnant within 5 months of discontinuing treatment with denosumab?  
Please select:  pregnant  planning to become pregnant  not pregnant or planning to become pregnant  
 none of the above (e.g. male, not a female of childbearing potential)

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## G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

### For Prolia Requests:

#### Post-menopausal osteoporosis

Yes  No Is there documentation that the trial of 2 oral and/or injectable bisphosphonates was ineffective?  
 Yes  No Is there documentation that a trial of 1 bisphosphonate AND 1 selective estrogen receptor modulator (SERM) was ineffective?  
 Please identify the failure of the medication trial:  Continued bone loss  Other: please identify: \_\_\_\_\_  
 Bisphosphonate #1 Date range: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Bisphosphonate #2 OR SERM Date range: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Yes  No Is there documented evidence that the patient has an intolerance to bisphosphonates and/or SERMs?  
 Select all that apply:  bisphosphonates  SERM  
 Yes  No Is there documented evidence that the patient has a contraindication to bisphosphonates and/or SERMs?  
 Select all that apply:  bisphosphonates  SERM

Please select which of the following bisphosphonates and/or SERM's was ineffective, not tolerated or contraindicated:  
 Select all that apply:  Alendronate (Binosto, Fosamax or Fosamax plus D)  Etidronate disodium (Didronel)  Ibandronate (Boniva)  
 Risedronate (Actonel, Actonel with Calcium or Atelvia)  Tiludronate (Skelid)  Zoledronic acid (Zometa, Reclast)  
 Raloxifene (Evista)  Tamoxifen (Nolvadex/Soltamox)  Toremifene citrate (Fareston)  Other: Please identify: \_\_\_\_\_

#### Prevention or treatment of osteoporosis in patients receiving aromatase inhibitors

Yes  No Is the patient receiving aromatase inhibitors?  
 Please indicate which of the following aromatase inhibitors is being used:  
 anastrozole (Arimidex)  exemestane (Aromasin)  letrozole (Femara)  Other: please identify: \_\_\_\_\_  
 Yes  No Is there documentation that the trial of oral and/or injectable bisphosphonates was ineffective?  
 Please identify the failure of the medication trial:  Continued bone loss  Other: please identify: \_\_\_\_\_  
 Bisphosphonate #1 Date range: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Bisphosphonate #2 Date range: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Yes  No Is there documented evidence that the patient has an intolerance to bisphosphonates?  
 Yes  No Is there documented evidence that the patient has a contraindication to bisphosphonates?  
 Please select which of the following bisphosphonates was ineffective, not tolerated or contraindicated:  
 Select all that apply:  Alendronate (Binosto, Fosamax or Fosamax plus D)  Etidronate disodium (Didronel)  Ibandronate (Boniva)  
 Risedronate (Actonel, Actonel with Calcium or Atelvia)  Tiludronate (Skelid)  Zoledronic acid (Zometa, Reclast)  
 Other: Please identify: \_\_\_\_\_

#### Treatment to increase bone mass in men receiving androgen deprivation therapy

Yes  No Does the patient have prostate cancer?  
 Yes  No Is the patient receiving androgen deprivation therapy?

#### Treatment of bone loss in men with osteoporosis

Yes  No Is there documentation that the trial of oral and/or injectable bisphosphonates was ineffective?  
 Please identify the failure of the medication trial:  Continued bone loss  Other: please identify: \_\_\_\_\_  
 Bisphosphonate #1 Date range: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Bisphosphonate #2 Date range: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Yes  No Is there documented evidence that the patient has an intolerance to bisphosphonates?  
 Yes  No Is there documented evidence that the patient has a contraindication to bisphosphonates?  
 Please select which of the following bisphosphonates was ineffective, not tolerated or contraindicated:  
 Select all that apply:  Alendronate (Binosto, Fosamax or Fosamax plus D)  Etidronate disodium (Didronel)  Ibandronate (Boniva)  
 Risedronate (Actonel, Actonel with Calcium or Atelvia)  Tiludronate (Skelid)  Zoledronic acid (Zometa, Reclast)  
 Other: Please identify: \_\_\_\_\_

#### Treatment of glucocorticoid-induced osteoporosis

Yes  No Is the patient initiating or continuing systemic glucocorticoids at a daily dosage equivalent to 7.5 mg or greater of prednisone?  
 Please select:  initiating systemic glucocorticoids  continuing systemic glucocorticoids  
 Yes  No Is the patient expected to remain on glucocorticoids for at least 6 months?  
 Yes  No Is there documentation that the trial of oral and/or injectable bisphosphonates was ineffective?  
 Please identify the failure of the medication trial:  Continued bone loss  Other: please identify: \_\_\_\_\_  
 Bisphosphonate #1 Date range: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Bisphosphonate #2 Date range: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Yes  No Is there documented evidence that the patient has an intolerance to bisphosphonates?  
 Yes  No Is there documented evidence that the patient has a contraindication to bisphosphonates?  
 Please select which of the following bisphosphonates was ineffective, not tolerated or contraindicated:  
 Select all that apply:  Alendronate (Binosto, Fosamax or Fosamax plus D)  Etidronate disodium (Didronel)  Ibandronate (Boniva)  
 Risedronate (Actonel, Actonel with Calcium or Atelvia)  Tiludronate (Skelid)  Zoledronic acid (Zometa, Reclast)  
 Other: Please identify: \_\_\_\_\_

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**G. CLINICAL INFORMATION (continued) - Required clinical information must be completed for ALL precertification requests.**

**For Xgeva Requests:**

**Bone metastases from solid tumors**

Please indicate which of the following pertains to the patient:  Bladder cancer  Breast cancer  Kidney cancer  Ovarian cancer  
 Non-small cell lung cancer  Prostate cancer  Thyroid cancer  
 Other: Please specify: \_\_\_\_\_

Giant cell tumor of the bone

Prevention of skeletal-related events in patients with multiple myeloma

**Treatment of hypercalcemia of malignancy**

Yes  No Has the patient been treated with intravenous bisphosphonate therapy?  
Please indicate the date range of therapy: \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_/\_\_\_\_/\_\_\_\_

Yes  No Is the hypercalcemia of malignancy refractory to intravenous bisphosphonate therapy?

Yes  No Has the albumin-corrected serum calcium level been tested?  
Please provide the albumin-corrected serum calcium level: \_\_\_\_\_mg/dL Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Continuation Requests: (Clinical documentation required for all requests)**

Yes  No Does the patient have a hypersensitivity to denosumab?

Please indicate what type of response the patient has experienced while on denosumab:  No response  Minimal response  Adequate response  
 Significant improvement

**H. ACKNOWLEDGEMENT**

**Request Completed By (Signature Required):** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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