aetna®

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

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

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Plans:
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:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid:** ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check one):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ 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

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

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 select all that apply: ☐ anorexia nervosa ☐ alcohol intake of 4 or more units a day ☐ corticosteroid therapy ☐ smoking
☐ Cushing's syndrome ☐ failed previous osteoporosis therapy ☐ high risk for falls ☐ history of osteoporosis fractures
☐ increasing age ☐ intolerant to previous osteoporosis therapy ☐ low body mass ☐ parental history of hip fracture
☐ rheumatoid arthritis ☐ other: please explain: _____

For Prolia Requests:

For 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?

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

For Post-menopausal osteoporosis

☐ Yes ☐ No Is there documentation that the trial of two 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: _____

Please select which of the following bisphosphonates and/or SERM's the patient tried

Select all that apply: ☐ Actonel or Actonel with Calcium (risedronate) ☐ Atelvia (risedronate) ☐ Boniva (ibandronate) ☐ Didronel (etidronate) ☐ Fosamax or Fosamax plus D (alendronate) ☐ Skelid (tiludronate) ☐ Zometa/Reclast (zoledronic acid) ☐ Fareston (toremifene citrate) ☐ Tamoxifen (nolvadex) ☐ Evista (raloxifene) ☐ Other: Please identify: _____

Bisphosphonate #1 Date range: _____/_____/_____ to _____/_____/____

Bisphosphonate #2 OR SERM Date range: _____/_____/_____ to _____/_____/____

☐ Yes ☐ No Is there documented evidence that the patient has an intolerance to bisphosphonates and/or SERMs?

→ ***Select all that apply:*** **Bisphosphonates**: ☐ Persistent upper GI disturbance ☐ Severe musculoskeletal pain ☐ Hypocalcemia ☐ Other: please explain: _____

SERM: ☐ Flu Syndrome ☐ Hot flashes ☐ Nausea/vomiting or diarrhea ☐ Arthralgia ☐ Rhinitis ☐ Other: please specify: _____

☐ Yes ☐ No Is there documented evidence that the patient has a contraindication to bisphosphonates and/or SERMs?

→ ***Select all that apply:*** **Bisphosphonates**: ☐ Renal Impairment ☐ Hypersensitivity to bisphosphonates or components ☐ Other: please identify: _____

SERM: ☐ Active or history of venous thromboembolism (e.g. DVT, PE, RVT) ☐ Hypersensitivity ☐ Hx. of CVA or TIA ☐ Other: please identify: _____

For Prevention of osteoporosis in patients receiving aromatase inhibitors

☐ Yes ☐ No Is the patient receiving aromatase inhibitors?

If yes, please indicate which of the following aromatase inhibitors is being used:

Select one: ☐ anastrozole (Arimidex) ☐ exemestane (Aromasin) ☐ letrozole (Femara) ☐ Other: please identify: _____

☐ Yes ☐ No Is there documentation that the trial of two oral and/or injectable bisphosphonates was ineffective?

If yes, please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____

Please select which of the following bisphosphonates the patient tried:

Select all that apply: ☐ Actonel or Actonel with Calcium (risedronate) ☐ Atelvia (risedronate) ☐ Boniva (ibandronate) ☐ Didronel (etidronate) ☐ Fosamax or Fosamax plus D (alendronate) ☐ Skelid (tiludronate) ☐ Zometa/Reclast (zoledronic acid) ☐ Other: Please identify: _____

Bisphosphonate #1 Date range: _____/_____/_____ to _____/_____/____

Bisphosphonate #2 Date range: _____/_____/_____ to _____/_____/____

☐ Yes ☐ No Is there documented evidence that the patient has an intolerance to two bisphosphonates?

→ ***Select all that apply:*** **Bisphosphonates**: ☐ Persistent upper GI disturbance ☐ Severe musculoskeletal pain ☐ Hypocalcemia ☐ Other: please explain: _____

☐ Yes ☐ No Is there documented evidence that the patient has a contraindication to two bisphosphonates?

→ ***Select all that apply:*** **Bisphosphonates**: ☐ Renal Impairment ☐ Hypersensitivity to bisphosphonates or components ☐ Other: please identify: _____

For Treatment of bone loss in men with osteoporosis

☐ Yes ☐ No Is there documentation that the trial of two oral and/or injectable bisphosphonates was ineffective?

If yes, please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____

Please select which of the following bisphosphonates the patient tried:

Select all that apply: ☐ Actonel or Actonel with Calcium (risedronate) ☐ Atelvia (risedronate) ☐ Boniva (ibandronate) ☐ Didronel (etidronate) ☐ Fosamax or Fosamax plus D (alendronate) ☐ Skelid (tiludronate) ☐ Zometa/Reclast (zoledronic acid) ☐ Other: Please identify: _____

Bisphosphonate #1 Date range: _____/_____/_____ to _____/_____/____

Bisphosphonate #2 Date range: _____/_____/_____ to _____/_____/____

☐ Yes ☐ No Is there documented evidence that the patient has an intolerance to two bisphosphonates?

→ ***Select all that apply:*** **Bisphosphonates**: ☐ Persistent upper GI disturbance ☐ Severe musculoskeletal pain ☐ Hypocalcemia ☐ Other: please explain: _____

☐ Yes ☐ No Is there documented evidence that the patient has a contraindication to two bisphosphonates?

→ ***Select all that apply:*** **Bisphosphonates**: ☐ Renal Impairment ☐ Hypersensitivity to bisphosphonates or components ☐ 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**

☐ **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 which of the following reactions the patient had:

☐ anaphylaxis ☐ dyspnea ☐ facial and upper airway edema ☐ hypotension ☐ pruritus ☐ rash ☐ uticaria

☐ other: _____

Please indicate what type of response the patient has experience on therapy:

Select appropriate response: ☐ 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.