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: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

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 #: _____
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 ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Xgeva (denosumab): 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 Initiation Requests (clinical documentation required for all requests):

☐ **Giant cell tumor of the bone**
☐ **Prevention of skeletal-related events (e.g. fractures) due to multiple myeloma or bone metastases from solid tumors**
☐ **Hypercalcemia of malignancy**
→ ☐ Yes ☐ No Is the patient's condition refractory to IV bisphosphonate (e.g., zoledronic acid, pamidronate) therapy?
→ ☐ Yes ☐ No Is there a clinical reason to avoid treatment with an IV bisphosphonate (e.g., acute renal impairment, renal insufficiency [creatinine clearance < 35 ml/min], history of intolerance to an IV bisphosphonate, hypocalcemia)?
☐ **Treatment for osteopenia or osteoporosis in patients with systemic mastocytosis**
→ ☐ Yes ☐ No Is the requested medication being used as second-line therapy for osteopenia or osteoporosis?
☐ Yes ☐ No Is the patient refractory to bisphosphonate therapy?
→ ☐ Yes ☐ No Is there a clinical reason for the patient to avoid therapy with bisphosphonates (e.g., renal insufficiency)?

For Continuation Requests (clinical documentation required for all requests):

☐ **Giant cell tumor of the bone**
☐ **Prevention of skeletal-related events (e.g. fractures) due to multiple myeloma or bone metastases from solid tumors**
☐ **Hypercalcemia of malignancy**
☐ **Treatment for osteopenia or osteoporosis in patients with systemic mastocytosis**
→ ☐ Yes ☐ No Is the patient diagnosed with hypercalcemia of malignancy?
☐ Yes ☐ No Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement?

Continued on next page

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: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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.