Denosumab (XGEVA®) Injectable Medication Precertification Request

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

Please indicate: ☐ Start of treatment ☐ Continuation of therapy **Today's date:** __________ **Date needed:** __________

Ship to: ☐ Doctor's office ☐ Patient ☐ Other: __________ Phone: __________

Dispensing Provider: ☐ Aetna Specialty Pharmacy® or ☐ Other: __________
Phone: __________ Fax: __________ **TIN:** __________ PIN: __________

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:
Patient Current Weight: ______ lbs or ______ kgs Patient 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: | *(Circle 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 *(Circle one)*: **Oncologist Hematologist Internal Medicine Other**: __________

D. DIAGNOSIS INFORMATION

Primary ICD-9:

☐ **170.0-170.9** Malignant Neoplasm of Bone and Articular Cartilage

☐ **185.0** Malignant Neoplasm of Prostate

☐ **198.5** Secondary Malignant Neoplasm/Bone and Bone Marrow

Other ICD-9 Code: __________

E. CLINICAL INFORMATION

☐ Yes ☐ No Does the patient have confirmed bone metastases from solid tumors?

F. PRESCRIPTION INFORMATION – To be completed only if Aetna Specialty Pharmacy is Dispensing Provider

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
XGEVA **CPB # 0804**				

***If Aetna Specialty Pharmacy is the dispensing pharmacy, patient benefits will be verified before product is shipped.**
***If the prescriber is providing the drug, the provider must verify benefits.**

Prescriber's Signature: __________ **Date:** ____/____/____
(Required by law if Aetna Specialty Pharmacy is the dispensing pharmacy.)

Interchange is mandated unless practitioner writes the words "NO SUBSTITUTION" in this space: __________