MEDICARE FORM

Xgeva® (denosumab) and biosimilars

Injectable Medication Precertification Request

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

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Aukelso, Bomyntra, denosumab-bnht, Jubereq, Osenvelt, Xbryk and Xtrenbo are non-preferred.

The preferred products vary by indication. See section G.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For Aetna Medicare Advantage and **Allina Health Aetna Medicare Members** send request to: **Phone:** 1-866-503-0857 **(TTY:** 711**)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare FIDE (HMO-DSNP) **Virginia Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Medicare FIDE (HMO-DSNP) **New Jersey Dual Eligible Special Needs Plans** send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Medicare FIDE (HMO D-SNP) **Illinois Dual Eligible Special Needs Plans** send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Medicare HIDE (HMO D-SNP) **Michigan Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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: _____

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 E-mail:		Office Contact Name:		Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office ☐ Home
☐ Outpatient Infusion Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

Dispensing Provider/Pharmacy:
☐ *Outpatient Dialysis Center* ☐ Physician's Office
☐ Retail Pharmacy ☐ Specialty Pharmacy
☐ Mail Order ☐ Other: _____
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

E. PRODUCT INFORMATION

Request is for:
☐ **Xgeva (denosumab)** ☐ **Wyost (denosumab-bbdz)** ☐ **Aukelso (denosumab-kyqq)** ☐ **Bilprevda (denosumab-nxxp)** ☐ **Bomnytra (denosumab-bnht)**
☐ **denosumab-bnht** ☐ **Jubereq (denosumab-desu)** ☐ **Osenvelt (denosumab-bmwo)** ☐ **Xbryk (denosumab-dssb** ☐ **Xtrenbo (denosumab-qbde)**

HCPCS Code: _____

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)

For Xgeva Requests:

Note: Aukelso (denosumab-kyqq), Bomyntra (denosumab-bnht), unbranded denosumab-bnht, Jubereq (denosumab-desu), Osenvelt (denosumab-bmwo), Xbryk (denosumab-dssb), and Xtrenbo (denosumab-qbde) are non-preferred.

For hypercalcemia of malignancy, prevention of skeletal-related events in patients with multiple myeloma, prevention of skeletal-related events in patients with bone metastases from solid tumors or prostate cancer, or treatment of osteopenia or osteoporosis in patients with systemic mastocytosis, the preferred products are pamidronate or zoledronic acid followed by Bilprevda (denosumab-nxxp), Wyost (denosumab-bbdz) or Xgeva (denosumab). Pamidronate and zoledronic acid do not require precertification.

☐ Yes ☐ No Has the patient received a dose of the requested drug through insurance in the last 365 days? This does not include samples or doses administered without prior authorization.

☐ Yes ☐ No Has the patient had a documented inadequate response to both a primary preferred product (pamidronate or zoledronic acid) and two or more secondary preferred products (Bilprevda [denosumab-nxxp], Wyost [denosumab-bbdz] and Xgeva [denosumab])? Medical records (e.g., chart notes) documenting an inadequate response to a trial of a primary preferred product and two or more secondary preferred products must be available upon request.
☐ pamidronate ☐ Bilprevda (denosumab-nxxp) ☐ Wyost (denosumab-bbdz) ☐ Xgeva (denosumab) ☐ zoledronic acid

When was the member's inadequate response to the preferred drug(s)?

_____

Please describe the nature of the inadequate response of the preferred drug(s)

_____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

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

☐ Yes ☐ No Has the patient had a documented intolerable adverse event to both a primary preferred product (pamidronate or zoledronic acid) and two or more secondary preferred products (Bilprevda [denosumab-nxxp], Wyost [denosumab-bbdz] and Xgeva [denosumab])? Medical records (e.g., chart notes) documenting an intolerable adverse event to a trial of a primary preferred product and two or more secondary preferred products must be available upon request

☐ pamidronate ☐ Bilprevda (denosumab-nxxp) ☐ Wyost (denosumab-bbdz) ☐ Xgeva (denosumab) ☐ zoledronic acid

When was the member's intolerable adverse event to the preferred drug(s)?

Please describe the nature of the intolerable adverse event to the preferred drug(s)

Please explain if there are any contraindications or any other medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply)

☐ pamidronate ☐ Bilprevda (denosumab-nxxp) ☐ Wyost (denosumab-bbdz) ☐ Xgeva (denosumab) ☐ zoledronic acid

What is the patient's serum creatinine and creatinine clearance? _____ mg/dL or _____ mL/min

For all other indications, the preferred products are Bilprevda (denosumab-nxxp), Wyost (denosumab-bbdz) and Xgeva (denosumab).

☐ Yes ☐ No Has the patient received a dose of the requested drug through insurance in the last 365 days? This does not include samples or doses administered without prior authorization.

☐ Yes ☐ No Has the patient had a documented intolerable adverse event to two or more preferred products (Bilprevda [denosumab-nxxp], Wyost [denosumab-bbdz] or Xgeva [denosumab])? Medical records (e.g., chart notes) documenting an intolerable adverse event to a trial of two or more preferred products must be available upon request

☐ Bilprevda (denosumab-nxxp) ☐ Wyost (denosumab-bbdz) ☐ Xgeva (denosumab)

Was the adverse event an expected adverse event attributed to the active ingredient as described in the prescribing information?

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use Bilprevda (denosumab-nxxp), Wyost (denosumab-bbdz) or Xgeva (denosumab).

What is the diagnosis or indication?

- ☐ Prevention of skeletal-related events due to multiple myeloma
- ☐ Bone metastases from a solid tumor (e.g., breast cancer, non-small cell lung cancer, thyroid carcinoma, kidney cancer, prostate cancer)
- ☐ Palliative care for bone metastases from thyroid carcinoma
- ☐ Treatment for osteopenia or osteoporosis in a patient with systemic mastocytosis
- ☐ Giant cell tumor of bone
- ☐ Hypercalcemia of malignancy
- ☐ Other

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

☐ Yes ☐ No Is the patient receiving benefit from therapy, defined as disease stability or disease improvement?

☐ Yes ☐ No Is Xgeva being used to treat hypercalcemia of malignancy?

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.