Excellus

Specialty Medication Review Program

Xgeva® (denosumab)
(Health Professional Administration)
Medical Benefit

Complete this form and fax to:

Medical Specialty Unit
Fax #: 1-800-306-0188
Phone #: 1-800-499-1275

If you are not **buying and billing** this medication, indicate which specialty pharmacy you will be using:

☐ **Accredo Health**
Fax: 1-888-773-7386
Phone: 1-866-413-4137

☐ **Walgreens Specialty Pharmacy**
Fax: 1-866-435-2173
Phone: 1-866-435-2171

☐ **Onco360**
Fax: 1-877-662-6355
Phone: 1-877-662-6633

☐ **Noble**
Fax: 1-888-842-3977
Phone: 1-888-843-2040

Complete all the following Patient/Prescriber information: (Please Print)

Patient Information	
Patient Name:	Patient Phone #: ( )
Patient ID #:	Patient Birthdate:
List Patient Allergy (If Any):	
Prescriber Information	
Prescriber Name:	Prescriber Specialty:
Prescriber Address:	
Prescriber Phone #:	Prescriber Fax #:
Prescriber NPI #:	Office Contact: Extension:

Location of Infusion:
☐ **Prescriber office** ☐ **Home/Homecare agency:**_____
☐ **Outpatient facility** ☐ **Other:** _____

Servicing Provider NPI (if different from the ordering prescriber):

Provide address of infusion location above for medication shipping:

Medication/Medical and Dispensing Information					
Medication (HCPCS)	**Dose**	**Frequency**	**Height**	**Weight (lbs./kgs)**	**Procedure Code**
Xgeva (J0897)					

Diagnosis/ICD-10:

Is this request for a: ☐ New Start **OR** ☐ Continuation of Therapy (recertification)?

Questions/Indications for Medical Necessity

**** See the Oncology CRPA Medical Drugs Policy (Pharmacy-64) for full Prior Authorization criteria ****

Select one of the following diagnoses:

☐ Giant Cell Tumor of Bone
☐ Hypercalcemia of Malignancy
☐ Bone Metastases from Solid Tumors
☐ Prevention of skeletal-related events in patients with Multiple Myeloma
☐ Other: _____

For Multiple Myeloma and Bone Metastasis from Solid Tumors	
1. If using for bone metastases from a solid tumor, does this patient have breast or prostate cancer?	☐ **Yes** ☐ **No**
2. Has this patient had failure of zoledronic acid?	☐ **Yes** ☐ **No**
3. Does this patient have a contraindication to zoledronic acid?	☐ **Yes** ☐ **No**
For Hypercalcemia of Malignancy	
1. Is this patient refractory to bisphosphonate therapy?	☐ **Yes** ☐ **No**

Provide any other comments/clinical justification:

ATTACH CLINICAL NOTES RELATED TO THIS REQUEST. IF DOCUMENTATION IS NOT PROVIDED, IT MAY DELAY THE REQUEST.

*Prescriber Signature: _____Date: _____

I certify the above is true and accurate to the best of my knowledge.