



**MEDICARE ADVANTAGE
PRIOR AUTHORIZATION REQUEST FORM**

Denosumab - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Member Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: <input type="checkbox"/> Medicare Advantage	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):

☐ **REQUEST FOR EXPEDITED REVIEW:** By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a continuation? If YES, go to 16. If NO, go to 2.

☐ Yes

☐ No

Q2. Is denosumab being used for the prevention of skeletal-related events in patients with multiple myeloma and patients with documented bone metastases from solid tumors? If YES, go to 5. If NO, go to 3.

☐ Yes

☐ No

Q3. Is denosumab being used in the treatment of adults and skeletally mature adolescents with documented giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity? If YES, go to 8. If NO, go to 4.

☐ Yes

☐ No

Q4. Is denosumab being used to treat hypercalcemia of malignancy refractory to bisphosphonates? If YES, go to 6.

☐ Yes

☐ No



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<p>Q5. Is there documentation showing a trial of, intolerance to, or contraindication to zoledronic acid? If YES, go to 8.</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q6. Is there documentation of albumin-corrected calcium greater than 12.5 mg/dL?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q7. Is there documentation of a trial of, intolerance to, or contraindication to IV bisphosphonates?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q8. Is there documentation showing calcium levels were checked, corrected prior to therapy and will be monitored while on therapy?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q9. Is there documentation showing the patient will be receiving supplementation with calcium and vitamin D?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q10. Is there documentation showing that an oral exam was done, and appropriate preventive dentistry was done prior to starting treatment?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Q11. Is there documentation showing that the patient is not pregnant or planning to become pregnant while on denosumab, if applicable?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p>Q12. Is there documentation showing the patient will be using highly effective contraception during treatment and for at least 5 months after the last dose of denosumab, if applicable?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p>
<p>Q13. Is the drug being prescribed by or in consultation with a hematologist or oncologist?</p>



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<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q14. Is the patient currently being treated with a denosumab containing product?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q15. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q16. Is the diagnosis hypercalcemia of malignancy refractory to bisphosphonates? If YES, go to 17. If NO, go to 18.	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q17. Is there documentation that the corrected serum calcium is less than 11.5 mg/dL?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q18. Is there documentation showing improvement or stabilization of disease?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q19. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
Q20. Requested Duration:	
<input type="checkbox"/> 12 Months	<input type="checkbox"/> Other:
Q21. Additional Information:	

Prescriber Signature

Date



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