



MEDICARE FORM

Prolia®, Xgeva® (denosumab) Injectable Medication Precertification Request

Page 1 of 4

(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: Xgeva is non-preferred.
The preferred products are
pamidronate or zoledronic acid.
Pamidronate and zoledronic acid
do not require precertification.

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.

<p>For Aetna Medicare Advantage and Allina Health Aetna Medicare members send request to:</p> <p>Phone: 1-866-503-0857 (TTY: 711)</p> <p>Fax: 1-844-268-7263</p> <p>Availity: https://www.aetna.com/health-care-professionals/resource-center/availability.html</p>
<p>For Aetna Medicare Advantage Virginia Dual Eligible Special Needs Plans (HMO D-SNP) send request to:</p> <p>Phone: 1-855-463-0933</p> <p>Fax: 1-833-280-5224</p> <p>Availity: https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal</p>
<p>For Aetna Assure Premier Plus Medicare Advantage New Jersey Dual Eligible Special Needs Plans (HMO D-SNP) send request to:</p> <p>Phone: 1-844-362-0934</p> <p>Fax: 1-833-322-0034</p> <p>Availity: https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html</p>
<p>For Aetna Better Health of Illinois Premier Medicare Medicaid Plan (MMP) send request to:</p> <p>Phone: 1-866-600-2139</p> <p>FAX: 1-855-320-8445</p> <p>Availity: https://www.aetnabetterhealth.com/illinois/providers/portal</p>
<p>For Aetna Better Health of Ohio Premier Medicare Medicaid Plan (MMP) send request to:</p> <p>Phone: 1-855-364-0974</p> <p>Fax: 1-855-734-9389</p> <p>Availity: https://www.aetnabetterhealth.com/ohio/providers/portal</p>
<p>For Aetna Better Health of Michigan Premier Medicare Medicaid Plan (MMP) send request to:</p> <p>Phone: 1-855-676-5772</p> <p>Fax: 1-844-241-2495</p> <p>Availity: https://www.aetnabetterhealth.com/michigan/providers/portal.html</p>



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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 #: _____	Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured: _____	Insured: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name:		(Check one): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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: <input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home <input type="checkbox"/> Outpatient Infusion Center Name: _____ <input type="checkbox"/> Home Infusion Center Phone: _____ Agency Name: _____ <input type="checkbox"/> Administration code(s) (CPT): _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____	Dispensing Provider/Pharmacy: <input type="checkbox"/> Outpatient Dialysis Center <input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy <input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Mail Order <input type="checkbox"/> Other: _____ Name: _____ Address: _____ City: _____ State: _____ ZIP: _____ Phone: _____ Fax: _____ TIN: _____ PIN: _____ NPI: _____
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E. PRODUCT INFORMATION

Request is for: Prolia Xgeva Dose: _____ Frequency: _____ 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)

Note: Xgeva is non-preferred. The preferred products are pamidronate or zoledronic acid. Pamidronate and zoledronic acid do not require precertification.

Yes No Has the patient had prior therapy with Xgeva (denosumab) within the last 365 days?

No Has the patient had a trial and failure of any of the following? (if yes, select all that apply below)

- pamidronate zoledronic acid
- When was the member's trial and failure of the preferred drug? _____
- Please describe the nature of the failure of the preferred drug _____

No Has the patient had an adverse reaction to any of the following? (if yes, select all that apply below)

- pamidronate zoledronic acid
- When was the member's adverse reaction to the preferred drug? _____
- Please describe the nature of the adverse reaction to the preferred drug _____

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 zoledronic acid

Please provide the patient's Bone Mineral Density (BMD) score and date obtained: T-score: _____ Date: ___ / ___ / ___

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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G. CLINICAL INFORMATION (continued) – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests: continued (Clinical documentation required for all requests)

Please indicate the location the BMD was measured: femoral neck lumbar spine total hip other: please identify: _____

Yes No Is the patient receiving 1000mg of calcium and 400 international units of vitamin D daily?

Yes No Does the patient have clinical evidence of uncorrected preexisting hypocalcemia?

Yes No Will the patient be using denosumab in combination with intravenous bisphosphonates?

Yes No Will the patient be using Prolia in combination with Xgeva?

Yes No Is the patient at high risk for fractures?

Yes No Has the patient had an osteoporotic fracture?

→ Yes No Does the patient have multiple risk factors for fractures?

Please explain (select all that apply): alcohol intake of 4 or more units per day parental history of hip fracture

rheumatoid arthritis current tobacco smoking advanced age frailty increased fall risk

glucocorticoid use none of the above

Yes No Does the patient have a high FRAX fracture probability: 10-year major osteoporotic fracture risk ≥ 20% or hip fracture risk ≥ 3%?

Yes No Is the patient pregnant or planning to become pregnant within 5 months of discontinuing treatment with denosumab?

→ Please select: pregnant planning to become pregnant not pregnant or planning to become pregnant

none of the above (e.g. male, not a female of childbearing potential)

For Prolia Requests:

Post-menopausal osteoporosis

Please select which of the following medication(s) was ineffective, not tolerated or contraindicated:

Select all that apply: Alendronate (Binosto, Fosamax or Fosamax plus D) Etidronate disodium (Didronel) Ibandronate (Boniva)

Risedronate (Actonel, Actonel with Calcium or Atelvia) Teriparatide (Forteo, Bonsity) Zoledronic acid (Zometa, Reclast)

Raloxifene (Evista) Tamoxifen (Nolvadex/Soltamox) Toremifene citrate (Fareston)

Other: Please identify: _____

Prevention or treatment of osteoporosis in patients receiving endocrine therapy for breast cancer

Yes No Is the patient receiving endocrine therapy for breast cancer?

→ Please indicate which of the following endocrine therapy (aromatase inhibitors) is being used:

anastrozole (Arimidex) exemestane (Aromasin) letrozole (Femara) Other: please identify: _____

Yes No Is there documentation that the trial of oral and/or injectable bisphosphonates was ineffective?

→ Please identify the failure of the medication trial: Continued bone loss Other: please identify: _____

Bisphosphonate #1 Date range: ____/____/____ - ____/____/____

Bisphosphonate #2 Date range: ____/____/____ - ____/____/____

Yes No Is there documented evidence that the patient has an intolerance to bisphosphonates?

Yes No Is there documented evidence that the patient has a contraindication to bisphosphonates?

Please select which of the following bisphosphonates was ineffective, not tolerated or contraindicated:

Select all that apply: Alendronate (Binosto, Fosamax or Fosamax plus D) Etidronate disodium (Didronel) Ibandronate (Boniva)

Risedronate (Actonel, Actonel with Calcium or Atelvia) Zoledronic acid (Zometa, Reclast)

Other: Please identify: _____

Treatment to increase bone mass in men receiving androgen deprivation therapy

Yes No Does the patient have prostate cancer?

Yes No Is the patient receiving androgen deprivation therapy?

Treatment of bone loss in men with osteoporosis

Yes No Is there documentation that the patient had an oral or injectable bisphosphonate trial of at least 1-year duration?

→ Please identify the failure of the medication trial: Continued bone loss Other: please identify: _____

Bisphosphonate #1 Date range: ____/____/____ - ____/____/____

Bisphosphonate #2 Date range: ____/____/____ - ____/____/____

Yes No Is there documented evidence that the patient has an intolerance to bisphosphonates?

Yes No Is there documented evidence that the patient has a contraindication to bisphosphonates?

Please select which of the following bisphosphonates was ineffective, not tolerated or contraindicated:

Select all that apply: Alendronate (Binosto, Fosamax or Fosamax plus D) Etidronate disodium (Didronel) Ibandronate (Boniva)

Risedronate (Actonel, Actonel with Calcium or Atelvia) Zoledronic acid (Zometa, Reclast)

Other: Please identify: _____

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G. CLINICAL INFORMATION (continued) - Required clinical information must be completed for ALL precertification requests.

For Prolia Requests continued:

Treatment of glucocorticoid-induced osteoporosis

Yes No Is the patient initiating or continuing systemic glucocorticoids at a daily dosage equivalent to 2.5 mg or greater of prednisone for 3 months or more?

→ Please select: initiating systemic glucocorticoids continuing systemic glucocorticoids

Yes No Is the patient expected to remain on glucocorticoids for at least 6 months?

Yes No Is there documentation that the trial of oral and/or injectable bisphosphonates was ineffective?

→ Please identify the failure of the medication trial: Continued bone loss Other: please identify: _____

Bisphosphonate #1 Date range: ____/____/____ - ____/____/____

Bisphosphonate #2 Date range: ____/____/____ - ____/____/____

Yes No Is there documented evidence that the patient has an intolerance to bisphosphonates?

Yes No Is there documented evidence that the patient has a contraindication to bisphosphonates?

Please select which of the following bisphosphonates was ineffective, not tolerated or contraindicated:

Select all that apply: Alendronate (Binosto, Fosamax or Fosamax plus D) Etidronate disodium (Didronel) Ibandronate (Boniva)

Risedronate (Actonel, Actonel with Calcium or Atelvia) Zoledronic acid (Zometa, Reclast)

Other: Please identify: _____

For Xgeva Requests:

Bone metastases from solid tumors

Please indicate which of the following pertains to the patient: Bladder cancer Breast cancer Kidney cancer Ovarian cancer

Non-small cell lung cancer Prostate cancer Thyroid cancer

Other: Please specify: _____

Giant cell tumor of the bone

Prevention of skeletal-related events in patients with multiple myeloma

Treatment of hypercalcemia of malignancy

Yes No Has the patient been treated with intravenous bisphosphonate therapy?

→ Please indicate the date range of therapy: ____/____/____ - ____/____/____

Yes No Is the hypercalcemia of malignancy refractory to intravenous bisphosphonate therapy?

Yes No Has the albumin-corrected serum calcium level been tested?

→ Please provide the albumin-corrected serum calcium level: _____ mg/dL Date: ____/____/____

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

Yes No Does the patient have a hypersensitivity to denosumab?

Please indicate what type of response the patient has experienced while on denosumab: No response Minimal response Adequate response

Significant improvement

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.