



Please complete ALL information below and fax your request to 1-888-671-5285

### Xgeva® Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

### Clinical Information (required)

**Select the diagnosis below:**

Giant cell tumor of bone

Hypercalcemia of malignancy

Skeletal prevention in multiple myeloma and bone metastasis from solid tumors (BMST)

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**For giant cell tumor of bone, answer the following:**

Does the patient have unresectable tumor?  Yes  No

Is surgical resection likely to result in severe morbidity?  Yes  No

Is Xgeva prescribed by or in consultation with an oncologist?  Yes  No

**Reauthorization:**

Does the patient show evidence of progressive disease while on Xgeva therapy?  Yes  No

**For hypercalcemia of malignancy, answer the following:**

Does the patient have history of failure, contraindication, or intolerance to one intravenous bisphosphonate (e.g., Aredia [pamidronate], Zometa [zoledronic acid])?  Yes  No

Is Xgeva prescribed by or in consultation with an oncologist?  Yes  No

**Reauthorization:**

Is there documentation the patient has had a positive clinical response to Xgeva therapy?  Yes  No

**For skeletal prevention in multiple myeloma and bone metastasis from solid tumors (BMST), answer the following:**

Select the patient's diagnosis:

Multiple myeloma

Solid tumors (e.g., breast cancer, kidney cancer, lung cancer, prostate cancer, thyroid cancer)

**For solid tumors:** Is there documented evidence of one or more metastatic bone lesions?  Yes  No

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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Please note: This request may be denied unless all required information is received.

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