Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Denosumab (Xgeva and biosimilars)

Fax back to: (833) 605-4407
Phone: (215) 991-4300

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	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 the 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 17. If NO, go to 2.

☐ Yes ☐ No

Q2. Is the Denosumab product 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 the Denosumab product 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 the Denosumab product being used to treat hypercalcemia of malignancy refractory to bisphosphonates? If YES, go to 6.

☐ Yes ☐ No

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Q5. Is there documentation showing a trial of, intolerance to, or contraindication to zoledronic acid? If YES, go to 8.

☐ Yes ☐ No

Q6. Is there documentation of albumin-corrected calcium greater than 12.5 mg/dL?

☐ Yes ☐ No

Q7. Is there documentation of a trial of, intolerance to, or contraindication to IV bisphosphonates?

☐ Yes ☐ No

Q8. Is there documentation showing calcium levels were checked, corrected prior to therapy and will be monitored while on therapy?

☐ Yes ☐ No

Q9. Is there documentation showing the patient will be receiving supplementation with calcium and vitamin D?

☐ Yes ☐ No

Q10. Is there documentation showing that an oral exam was done, and appropriate preventive dentistry was done prior to starting treatment?

☐ Yes ☐ No

Q11. Is there documentation showing that the patient is not pregnant or planning to become pregnant while on the Denosumab product, if applicable? If YES, go to 12. If NO, refer to Medical Director. If N/A, skip to 13.

☐ Yes ☐ No ☐ NA

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 the Denosumab product, if applicable?

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☐ Yes ☐ No

Q13. Is the prescriber a hematologist or oncologist?

☐ Yes ☐ No

Q14. Is the patient currently being treated with Prolia?

☐ Yes ☐ No

Q15. Is the request for a formulary product?

☐ Yes ☐ No

Q16. For non-formulary products, has documentation of inadequate response, intolerance, or contraindication to formulary agents indicated for patient's diagnosis that would not be expected to occur with requested agent been provided?

☐ Yes ☐ No

Q17. Is the diagnosis hypercalcemia of malignancy refractory to bisphosphonates? If YES, go to 18. If NO, go to 19.

☐ Yes ☐ No

Q18. Is there documentation that the corrected serum calcium is less than 11.5 mg/dL? Documentation must be attached.

☐ Yes ☐ No

Q19. Is there documentation showing improvement or stabilization of disease?

☐ Yes ☐ No

Q20. Additional Information:

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Patient Name:	**Prescriber Name:**

_____ _____

Prescriber Signature Date

v2026

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