# Xgeva

## Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

**Patient's Name:** _____ **Date**: _____
**Patient's ID:** _____ **Patient's Date of Birth:** _____
**Physician's Name:** _____
**Specialty:** _____ **NPI#:** _____
**Physician Office Telephone:** _____ **Physician Office Fax:** _____

**Referring Provider Info:** ❑ **Same as Requesting Provider**
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____

**Rendering Provider Info:** ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
**Name:** _____ **NPI#:** _____
**Fax:** _____ **Phone:** _____

***Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.***

**Required Demographic Information:**

*Patient Weight:* _____*kg*

*Patient Height:*_____*cm*

*Please indicate the place of service for the requested drug:*

| | | |
|---|---|---|
| ❑ *Ambulatory Surgical* | ❑ *Home* | ❑ *Off Campus Outpatient Hospital* |
| ❑ *On Campus Outpatient Hospital* | ❑ *Office* | ❑ *Pharmacy* |

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**



**CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062**
**Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com**

**Criteria Questions:**

1. What is the diagnosis?
   - ❑ Giant cell tumor of the bone
   - ❑ Prevention of skeletal-related events due to multiple myeloma or bone metastases from solid tumors
   - ❑ Palliative care for bone metastases from thyroid carcinoma
   - ❑ Hypercalcemia of malignancy
   - ❑ Treatment for osteopenia or osteoporosis in patients with systemic mastocytosis
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the request for continuation of therapy with the requested medication?
   ❑ Yes ❑ No *If No, skip to diagnosis section.*
4. Is the patient experiencing a benefit from therapy with the requested medication as evidenced by disease stability or disease improvement? ❑ Yes ❑ No *No further questions.*

***Complete the following section based on the patient's diagnosis, if applicable.***

Section A: Hypercalcemia of Malignancy

5. Is the patient's condition refractory to IV bisphosphonate therapy? *If Yes, no further questions.* ❑ Yes ❑ No
6. Is there a clinical reason to avoid treatment with an IV bisphosphonate (e.g., acute renal impairment, renal insufficiency [creatinine clearance < 35 ml/min], history of intolerance to an IV bisphosphonate)?
   ❑ Yes ❑ No

Section B: Treatment for Osteopenia or Osteoporosis in Patients with Systemic Mastocytosis

7. Is the patient refractory to bisphosphonate therapy and will be using the requested medication as second-line therapy? *If Yes, no further questions.* ❑ Yes ❑ No
8. Is there a clinical reason for the patient to avoid therapy with bisphosphonates (e.g., renal insufficiency)?
   ❑ Yes ❑ No

***I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.***

**X_____**
**Prescriber or Authorized Signature** **Date (mm/dd/yy)**

**Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720**