



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.

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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

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Xgeva SGM – 04/2021.

**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
 - 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)

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