BlueCross BlueShield
Federal Employee Program

Send completed form to:
Blue Shield of California
Fax: 855-895-3504

PROLIA/ XGEVA PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form. All incomplete and illegible forms will be returned to the patient.

CARDHOLDER AND PATIENT INFORMATION

Cardholder Name: _____/ _____/ _____
First MI Last

Patient Name: _____/ _____/ _____
First MI Last

Patient Address: _____
Street

_____
City State Zip

Patient Date of Birth: ____/ ____/ ____ Sex: M ____ F ____ **R** | | | | | | | | | |
Cardholder Identification Number

PHYSICIAN COMPLETES

Prolia (denosumab)

NOTE: Form must be completed in its **entirety** for processing

1. What is the patient's **diagnosis?**
   - ❑ **Osteoporosis**
   - ❑ **Breast cancer** ***(please answer the following question):***
     a. Is the patient receiving aromatase-inhibitor therapy*? ❑Yes ❑No
     Examples include, but not limited to: anastrozole (Arimidex), letrozole (Femara) and exemestane (Aromasin)
   - ❑ **Prostate cancer** ***(please answer the following questions):***
     a. Is the patient's prostate cancer metastatic? ❑Yes ❑No
     b. Is the patient receiving androgen deprivation therapy*? ❑Yes ❑No
     Examples include, but not limited to: bicalutamide (Casodex), flutamide (Eulexin), nilutamide (Nilandron), leuprolide (Lupron Eligard), and goserelin (Zoladex)
   - ❑ **Other diagnosis** ***(please specify):*** _____

2. Does the physician agree that the patient will not receive more than two (2) doses per year? ❑Yes ❑No*
   ***If NO,** please specify number of desired doses per year? _____

3. Will the patient use Prolia concurrently with another RANKL-inhibitor agent? ❑Yes ❑No

4. Has the patient been on therapy with Prolia for **6 months** continuously, excluding samples?
   ❑**YES** – this would be the **CONTINUATION** of therapy.

   ❑**NO** – this would be the **INITIATION** of therapy, please answer the following questions:
   a. Has the patient experienced inadequate treatment response, intolerance, or contraindication to bisphosphonate therapy? ❑Yes ❑No
   b. Does the physician agree to correct any pre-existing hypocalcemia, if present, before initiation of therapy? ❑Yes ❑No
   c. Is the patient at high risk for bone fracture(s)? ❑Yes ❑No

Xgeva (denosumab)

NOTE: Form must be completed in its **entirety** for processing

1. What is the patient's **diagnosis?**
   - ❑ **Bone tumor (*please answer the following questions)***
     a. Does the patient have giant cell tumor of the bone? ❑Yes ❑No
     b. Does the patient have a concurrent diagnosis of multiple myeloma? ❑Yes ❑No
   - ❑ **Bone metastases (*please answer the following questions)***
     a. Does the patient have bone metastases from solid tumors? ❑Yes ❑No
     b. Does the patient have a concurrent diagnosis of multiple myeloma? ❑Yes ❑No
   - ❑ **Hypercalcemia (*please answer the following question)***
     a. Does the patient have hypercalcemia of malignancy? ❑Yes ❑No
   - ❑ **Other diagnosis *(please specify):*** _____

2. Will the patient be using Xgeva with another RANKL-inhibitor? ❑Yes ❑No

3. How many vials are being requested for an 84 day supply? _____ vials per 84 days

4. Has the patient been on therapy with Xgeva continuously for the last **2 months**, excluding samples?

❑**YES** – this would be the **CONTINUATION** of therapy.

❑**NO** – this would be the **INITIATION** of therapy, please answer the following questions for the appropriate diagnosis:

Giant cell tumor of bone ***(please answer the following questions)***

a. Is the cancer unresectable or is surgical resection not recommended? ❑Yes ❑No

b. Does the physician agree to correct any pre-existing hypocalcemia prior to therapy? ❑Yes ❑ No

Bone metastases from solid tumors (*please answer the following questions)*

a. Is the patient at high risk for skeletal-related events? ❑Yes ❑No

b. Does the physician agree to correct any pre-existing hypocalcemia prior to therapy? ❑Yes ❑ No

c. Has the patient experienced inadequate treatment response, intolerance, or contraindication to **ONE** of the following? ***(Please select ONE of the following below)***

❑IV Bisphosphonate ❑Pamidronate ❑Zoledronic acid ❑None of the above

Hypercalcemia of malignancy ***(please answer the following question)***

a. Has the patient's disease relapsed or progressed after bisphosphate therapy? ❑Yes ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

_____ (_____) _____ (_____) _____

Physician Name (Print Clearly) Phone Fax

_____ _____ _____ _____

Street Address City State Zip

_____ _____ _____/ _____ / _____

Prescriber's NPI Physician Signature Date