Xgeva Prior Authorization Form

Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (866) 440-9345
Phone: (800) 932-3918

Date (MM/DD/YYYY): _____

Patient Information

Name: _____ DOB (MM/DD/YYYY): _____

Medicaid Assistance Number: _____ Sex: ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Phone: _____ Fax: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Dose:

❑ Xgeva® 120 mg subcutaneously every 4 weeks, with additional doses on days 8 and 15 of the first month of treatment.
❑ Xgeva®120 mg subcutaneously every 4 weeks.

Yes	No	**Xgeva®**
❑	❑	Does the patient have a diagnosis of giant cell tumor of the bone?
❑	❑	Does the patient have a tumor that is either recurrent, unresectable or where surgical resection is likely to cause severe morbidity?
❑	❑	Is the patient a skeletally mature adolescent with a weight > 45 kg?
❑	❑	Does that patient have a diagnosis of bone metastases from solid tumors?
❑	❑	Does the patient have a diagnosis of hypercalcemia of malignancy?
❑	❑	Is the hypercalcemia refractory to intravenous bisphosphonate therapy?
❑	❑	Does the patient have any contraindications to Xgeva® therapy (hypocalcemia, hypersensitivity to ingredients)?
❑	❑	Is patient currently receiving Prolia®? Xgeva® includes the same active ingredient (denosumab) found in Prolia®. Patients receiving Xgeva® should not take Prolia®.

I attest that:

❑ The benefits of the treatment outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge

❑ The MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original.

Prescriber's Signature: _____ Date (MM/DD/YYYY): _____