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

Xgeva® Prior Authorization Form

Patient's Information: DATE: _____

NAME: DOB:

Recipient's Maryland Medicaid Number: SEX: ❑ M ❑ F

Prescriber's Information:

NAME: NPI #

Phone # Fax #

Contact Person for this Request:

NAME: Phone: Fax:

Y	N	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®.

Dose:

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

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Directions for use:

I certify that all the above information is accurate and will be made available for audit if requested.

Prescriber's Signature_____ Date_____

Fax this completed form to 866-440-9345. Incomplete forms will not be reviewed.