



## DENOSUMAB (Prolia™ or Xgeva™)

### PRIOR REVIEW/CERTIFICATION FAXBACK FORM

**INCOMPLETE FORMS MAY DELAY PROCESSING**

**ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

**Answer the following questions if prescribing PROLIA ONLY:** **Dx code:** \_\_\_\_\_

1. Please check a box below if one or more of the following circumstances applies:

- The patient is a postmenopausal woman at high risk for fracture (i.e., the patient has had an osteoporotic fracture or has multiple risk factors for fracture).
- The patient is receiving aromatase inhibitors (anastrozole, letrozole, exemestane) and is using Prolia for the prevention of osteoporosis.

2. If a box is checked in **Question #1**, please answer the following question:  
 Has the patient failed or is unable to tolerate at least ONE oral bisphosphonate or has contraindications to receiving treatment with an oral bisphosphonate? .....  Yes  No

3. Please check a box if one of the following circumstances applies:

- The patient is a woman at high risk for fracture receiving adjuvant aromatase inhibitors (i.e. anastrozole, letrozole, exemestane) for breast cancer and is using Prolia to increase bone mass.
- The patient is a man at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer and is using Prolia to increase bone mass.
- Other (*Medical record documentation may be required*)

**Answer the following question if prescribing XGEVA ONLY:** **Dx code:** \_\_\_\_\_

Does this patient have bone metastases from solid tumors and is using Xgeva for the prevention of skeletal-related events? .....  Yes  No

**Please certify the following by signing and dating below:**

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

**For BCBSNC members, fax form to 1-800-795-9403**

**For NC State Health Plan members (Member ID starts with YPY), fax form to 1-866-225-5258**