



HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Xgeva - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Form with two columns: Patient Name and Prescriber Name. Fields include Member Number, Date of Birth, Line of Business, Address, City, State ZIP, Primary Phone, Fax, Office Contact, NPI, State Lic ID, Address, City, State ZIP, and Specialty/facility name.

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval. Please answer the following questions and sign.

Seven question blocks (Q1-Q7) regarding Xgeva usage, each with Yes/No checkboxes. Q1: Is this a continuation? Q2: Is Xgeva being used for the prevention of skeletal-related events... Q3: Is Xgeva being used in the treatment of adults and skeletally mature adolescents... Q4: Is Xgeva being used to treat hypercalcemia... Q5: Is there documentation showing a trial of, intolerance to, or contraindication to zoledronic acid? Q6: Is there documentation of albumin-corrected calcium greater than 12.5 mg/dL? Q7: Is there documentation of a trial of, intolerance to, or contraindication to IV bisphosphonates?

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Patient Name:

Prescriber Name:

Q8. Is there documentation showing calcium levels were checked, corrected prior to therapy and will be monitored while on therapy?

Yes checkbox

No checkbox

Q9. Is there documentation showing the patient will be receiving supplementation with calcium and vitamin D?

Yes checkbox

No checkbox

Q10. Is there documentation showing that an oral exam was done, and appropriate preventive dentistry was done prior to starting treatment?

Yes checkbox

No checkbox

Q11. Is there documentation showing that the patient is not pregnant or planning to become pregnant while on Xgeva, if applicable?

Yes checkbox

No checkbox

Q12. Is there documentation showing the patient will be using highly effective contraception during treatment and for at least 5 months after the last dose of Xgeva, if applicable?

Yes checkbox

No checkbox

Q13. Is the prescriber a Hematologist or Oncologist?

Yes checkbox

No checkbox

Q14. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D? If Yes, go to 19.

Yes checkbox

No checkbox

Q15. Is the diagnosis hypercalcemia of malignancy refractory to bisphosphonates?

Yes checkbox

No checkbox

Q16. Is there documentation that the corrected serum calcium is less than 11.5 mg/dL? Documentation must be attached.

Yes checkbox

No checkbox

Q17. Is there documentation showing improvement or stabilization of disease?

Yes checkbox

No checkbox

Q18. Does the prescriber want to have the medication provided by a pharmacy and covered under Medicare Part D?

Yes checkbox

No checkbox

Q19. Additional Information:



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Patient Name:

Prescriber Name:

Q20. Duration:

12 months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request