reliance|rx℠
15 Earhart Drive, Suite 101, Amherst, NY 14221

XGEVA AUTHORIZATION AND RE-AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:	Today's Date:	Date Needed:
Date of birth: Sex: Weight:	Prescriber:	Specialty:
Home Phone Number: ( )	Phone Number: ( )	Fax Number: ( )
Home Address: City: State: Zip:	Address:	City: State: Zip:
Payor: ☐ Commercial ☐ Medicare ☐ Medicaid ☐ Self-funded ☐ Independent Health ☐ Anne Arundel Health System ☐ Pharmacy Benefit Dimensions Insurance ID: Group Number:	Allergies:	

DRUG NAME: XGEVA

Dose: _____

Frequency: _____

For all indications, please submit the following:

☐ Documentation showing patient has been advised of the importance of proper oral hygiene practices to avoid invasive dental procedures during treatment.

☐ Documentation showing that female patients of reproductive potential have been advised of potential risk to the fetus and should use effective contraception during therapy and for at least 5 months after the last dose of Xgeva.

STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____

ICD10 Code: _____

☐ Medication is being requested for the prevention of SREs in adult patients with multiple myeloma and in patients with bone metastases from solid tumors.

OR

☐ Medication is being requested for the treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity

☐ Patient's serum calcium level submitted
AND
☐ Documentation submitted showing that patient has been instructed on the symptoms of hypocalcemia and the importance of adequate calcium, magnesium, and vitamin D supplementation while on therapy.

OR

☐ Medication is being requested for the treatment of hypercalcemia of malignancy **AND**

- ☐ Patient must have a diagnosis of refractory hypercalcemia of malignancy defined as albumin-corrected calcium greater than 12.5 mg/dl (3.1 mmol/L) despite treatment with a minimum 7 day trial on a previous therapy with intravenous (IV) bisphosphonates such as ibadronate or zoledronic acid **OR**
- ☐ Patient has documented contraindication or intolerance to IV bisphosphonates such as ibadronate or zoledronic acid.