



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	GENDER
			F M
PRACTICE ADDRESS	CITY	STATE	ZIP

Answer the following questions if prescribing PROLIA ONLY: Diagnosis code: _____

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

- The patient is a postmenopausal woman with osteoporosis at high risk for fracture (i.e., the patient has had an osteoporotic fracture or has multiple risk factors for fracture). **** New Requests Require Dexascan Results****
- 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?
- Does the patient have contraindications to receiving treatment with an oral bisphosphonate?

Please list contraindication: _____

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.
- The patient is a man with osteoporosis at high risk for fracture and is using Prolia to increase bone mass.
- Other (*Medical record documentation required*) _____

Answer the following question if prescribing **XGEVA ONLY**:

Diagnosis code: _____

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

- The patient has hypercalcemia of malignancy refractory to bisphosphonate therapy.
- The patient has bone metastases from solid tumors and is using Xgeva for the prevention of skeletal-related events.
- The patient is an adult or skeletally mature adolescent and is using Xgeva for the treatment of giant cell tumor of the bone that is unresectable or where surgical resection is likely to result in severe morbidity.
- Other _____ (Medical record documentation required)

***** New Requests Require Dexascan Results *****

Effective 9/2015

PHYSICIAN ATTESTATION: By signing 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.

Please certify the following by signing and dating below:

*Physician signature: _____ Date: _____

(*Original Physician signature required. Stamped signatures not acceptable)

For BCBSNC members, fax form to 1-800-571-7942

For NC State Health Plan members, fax form to 1-866-225-5258

For APPEALS for BCBSNC Members, fax form to 919-765-4409

For APPEALS for NC State Health Plan Members, fax form to 919-765-2322

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