Prescriber Criteria Form

Denosumab BDC 2026 PA Fax 637-A v5 010126.docx
Xgeva (denosumab), Bilprevda (denosumab-nxxp), Bomyntra (denosumab-bnht), Osenvelt (denosumab-bmwo), Wyost (denosumab-bbdz)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Denosumab.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.

B vs D CRITERIA FOR DETERMINATION

1	Is the requested drug being supplied from the practitioner and/or office stock supply and billed as part of a practitioner service (i.e., the drug is being furnished "incident to a practitioner's service")? [If yes, then no further questions.]	Yes	No

CRITERIA FOR APPROVAL

2	Does the patient have giant cell tumor of the bone? [If yes, then no further questions.]	Yes	No
3	Is the requested drug being prescribed for the prevention of skeletal-related events due to multiple myeloma or bone metastases from solid tumors? [If yes, then no further questions.]	Yes	No
4	Does the patient have hypercalcemia of malignancy? [If no, then no further questions.]	Yes	No
5	Is the condition refractory to intravenous (IV) bisphosphonate therapy or is there a clinical reason to avoid IV bisphosphonate therapy?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____