PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xgeva

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department 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 left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

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

Q1. What diagnosis is this drug being prescribed for (pick one)?

- ☐ Prevention of skeletal-related events in patients with bone metastases from solid tumors
- ☐ Treatment of adults and skeletally mature adolescents with giant cell tumor of bone
- ☐ Treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis

Q3. Please indicate location of administration.

- ☐ Home
- ☐ Long Term Care (LTC) facility
- ☐ Physician office (drug from office stock - buy and bill)
- ☐ Physician office (MEMBER to obtain drug from PHARMACY with a prescription)

Q4. If using for for the treatment of adults and skeletally mature adolescents with giant cell tumor of bone, is the tumor unresectable or is surgical resection likely to result in severe morbidity?

☐ Yes ☐ No

Q5. Does the patient have multiple myeloma?

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Xgeva

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department 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 left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**

☐ Yes ☐ No
Q6. Is the prescribing physician an Oncologist or Hematologist? ☐ Yes ☐ No
Q7. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.