



Xgeva[®] (denosumab)

Enrollment Form

For Blue Cross Blue Shield of Rhode Island Members

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Date: _____ Needs by Date (Please Specify): _____

Ship to: Patient Office Other: _____

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: _____
 Address: _____
 City, State, Zip: _____
 Home Phone: _____
 Alternate Phone: _____
 SS #: _____
 Insurance ID: _____
 Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
 State License #: _____ UPIN: _____
 DEA #: _____ NPI #: _____
 Group or Hospital: _____
 Address: _____
 City, State Zip: _____
 Phone: _____ Fax: _____
 Contact Person: _____
 Contact Phone: _____

INSURANCE INFORMATION *(Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card:	Name of Insurer: _____	ID#: _____	BIN: _____	PCN: _____	Group: _____
Primary Insurance:	Subscriber: _____	ID#: _____	Name of Insurer: Blue Cross Blue Shield of RI	Phone: _____	
Secondary Insurance:	Subscriber: _____	ID#: _____	Name of Insurer: _____	Phone: _____	

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has a diagnosis of multiple myeloma Yes No
- Patient has bone metastases from a solid tumor Yes No
- Document patients primary cancer _____
- Patient has pre-existing hypocalcemia Yes No
- Hypocalcemia will be corrected prior to starting Xgeva Yes No
- Patient will receive calcium and vitamin D as needed to treat or prevent hypocalcemia Yes No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Xgeva [®] (denosumab)	<input type="checkbox"/> 120 mg/1.7 mL vial	<input type="checkbox"/> Inject 120 mg SC every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 Week Supply <input type="checkbox"/> Other: _____	

X _____
 PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
 DISPENSE AS WRITTEN (Date)