AvMed

MEDICAL PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-877-535-1391**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization can be delayed**.

For Medicare Members: Medicare Coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx. Additional indications may be covered at the discretion of the health plan.

Denosumab Biosimilars for Osteoporosis Indications (Medical)

Drug Requested: select one drug below

PREFERRED [No Prior Authorization Required]	
❑ **Q5136 Jubbonti®** (denosumab-bbdz)	❑ **Q5157 Stoboclo®** (denosumab-bmwo)
NON-PREFERRED [Prior Authorization Required]	
❑ **Q5162 Bildyos®** (denosumab-nxxp)	❑ **Q5159 Ospomyv™** (denosumab-dssb)
❑ **Q5161 Bosaya™** (denosumab-kyqq)	❑ **Q5166 Osvyrti®** (denosumab-desu)
❑ **Q5158 Conexxence®** (denosumab-bnht)	❑ **J0897 Prolia®** (denosumab)
❑ **Q5167 Enoby™** (denosumab-qbde)	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

(Continued on next page)

❑ Standard Review. In checking this box, the timeframe does not jeopardize the life or health of the member or the member's ability to regain maximum function and would not subject the member to severe pain.

Quantity Limits:

- Osteoporosis, fracture risk reduction: 60 mg subcutaneously administered by a healthcare professional once every 6 months. Available dosage form: Single use prefilled syringe and a single use vial containing 1 mL of 60 mg/mL solution.
- 60 billable units every 6 months

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. **Applicable to ALL continuation of therapy requests**

❑ **Diagnosis: Osteoporosis**

Initial Authorization: 12 months

❑ If requesting a non-preferred product, member must have a documented trial with an inadequate response, or intolerability to the preferred biosimilar denosumab products, Jubbonti® (denosumab-bbdz) **AND** Stoboclo® (denosumab-bmwo)

Reauthorization: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. **Applicable to ALL continuation of therapy requests.**

❑ **Diagnosis: Osteoporosis**

❑ If requesting a non-preferred product, member must have a documented trial with an inadequate response, or intolerability to the preferred biosimilar denosumab products, Jubbonti® (denosumab-bbdz) **AND** Stoboclo® (denosumab-bmwo)

Medication being provided by (check applicable box(es) below):

❑ **Physician's office** **OR** ❑ **Specialty Pharmacy**

For urgent reviews: Practitioner should call AvMed Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. AvMed definition of urgent is a lack of treatment that could seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

***Approved by Pharmacy and Therapeutics Committee**: ~~11/20/2025;~~ 7/23/2026
REVISED/UPDATED/REFORMATTED: ~~12/4/2025;~~ **8/28/2026**