SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY 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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

The Sentara Health Plans Oncology Program is administered by OncoHealth

- **For any oncology indications**, the most efficient way to submit a prior authorization request is through the **OncoHealth OneUM Provider Portal** at https://oneum.oncohealth.us. Fax to **1-800-264-6128.**

OncoHealth can also be contacted by Phone: 1-888-916-2616.

Denosumab Biosimilars for Oncology Indications (PHARMACY)

Drug Requested: select one drug below

PREFERRED **Trial and failure of Xtrenbo™ is required prior to the use of Osenvelt® or Wyost®**	
❑ **Xtrenbo**™ (denosumab-qbde)	
❑ **Osenvelt**® (denosumab-bmwo)	❑ **Wyost**® (denosumab-bbdz)
NON-PREFERRED **Trial and failure of Xtrenbo™ and either Osenvelt® or Wyost® is required prior to the use of any non-preferred denosumab biosimilar product**	
❑ **Aukelso**™ (denosumab-kyqq)	❑ **Bilprevda**® (denosumab-nxxp)
❑ **Bomyntra**® (denosumab-bnht)	❑ **Jubereq** (denosumab-desu)
❑ **Xgeva**® (denosumab)	❑ **Xbryk**™ (denosumab-dssb)

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

Member Name: _____

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

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

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

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

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

Quantity Limits:

For Oncology Use: 120 mg subcutaneously administered by a healthcare professional once every 4 weeks.
Available dosage form: Single use prefilled syringe and a single use vial containing 120 mg/1.7 mL solution.

GENERAL 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.**

- ❑ The member will receive calcium and vitamin D as necessary to treat or prevent hypocalcemia
- ❑ The member does not have hypocalcemia
- ❑ The provider attests that the requested product will not be used in combination with other denosumab products, bisphosphonates, romosozumab, or parathyroid hormone analogs/related peptides
- ❑ If requesting **Osenvelt® or Wyost®,** member must have a documented trial with an inadequate response, or intolerability to Xtrenbo™, as indicated on the PDL:

  http://www.virginiamedicaidpharmacyservices.com/provider/preferred-drug-list/
- ❑ If requesting a **non-preferred product**, member must have a documented trial with an inadequate response, or intolerability to the preferred biosimilar denosumab products:
  - ❑ Xtrenbo™ **AND**
  - ❑ Osenvelt® (denosumab-bmwo) **OR** Wyost® (denosumab-bbdz)

❑ **Diagnosis: Prevention of skeletal-related events in patients with multiple myeloma OR bone metastases from solid tumors**

Initial Authorization: 6 months

- ❑ The member is 18 years of age and older
- ❑ The member had an inadequate response, contraindication* or intolerance to at least a 3-month trial of zoledronic acid
- ❑ Member has metastatic breast cancer, metastatic castration-resistant prostate cancer, or metastatic lung cancer (both SCLC, and NSCLC)

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❑ **Diagnosis: Giant cell tumor of the bone**

Initial Authorization: 6 months

- ❑ The member is 12 years of age or older and skeletally mature
- ❑ The disease is unresectable or surgical resection is likely to result in severe morbidity

❑ **Diagnosis: Hypercalcemia of malignancy**

Initial Authorization: 6 months

- ❑ The member is 18 years of age or older
- ❑ The member has a diagnosis of cancer
- ❑ The member has a diagnosis of refractory hypercalcemia of malignancy defined as an albumin-corrected calcium of >12.5 mg/dL (3.1 mmol/L) despite treatment with a minimum seven (7) day trial on previous therapy with intravenous (IV) bisphosphonates such as ibandronate or zoledronic acid
- ❑ The member has a documented contraindication* or intolerance to intravenous (IV) bisphosphonates such as ibandronate or zoledronic acid

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**

- ❑ The member continues to meet the relevant criteria identified in the initial criteria
- ❑ The member has an absence of unacceptable toxicity from the drug
- ❑ The member is being continuously monitored for response to therapy which indicates a beneficial response

***Examples of contraindications to injectable bisphosphonate therapy include the following:**

- Documented pre-existing hypocalcemia
- Documented pre-existing renal insufficiency defined as creatinine clearance < 30-35 mL/min

Medication being provided by Specialty Pharmacy – Proprium Rx

*****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**
REVISED/UPDATED/REFORMATTED: ~~12/12/2025, 3/26/2026; 6/15/2026~~**, 7/13/2026**