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.**

Denosumab Biosimilars for Osteoporosis Indications (PHARMACY)

Drug Requested: (Select one drug below)

PREFERRED **Trial and failure of Enoby™ is required prior to the use of Jubbonti® or Stoboclo®**	
❑ **Enoby™** (denosumab-qbde)	
❑ **Jubbonti®** (denosumab-bbdz)	❑ **Stoboclo®** (denosumab-bmwo)
NON-PREFERRED **Trial and failure of Enoby™ and either Jubbonti® or Stoboclo® is required prior to the use of any non-preferred denosumab biosimilar product**	
❑ **Bosaya™** (denosumab-kyqq)	❑ **Conexxence®** (denosumab-bnht)
❑ **Bildyos®** (denosumab-nxxp)	❑ **Ospomyv™** (denosumab-dssb)
❑ **Osvyrti®** (denosumab-desu)	❑ **Prolia®** (denosumab)

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 #: _____

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:** _____

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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.

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**

- ❑ Member is 18 years of age and older
- ❑ Member is supplementing with 1,000mg of calcium and at least 400IU of vitamin D daily
- ❑ The member does not have hypocalcemia
- ❑ Confirmation that member is not pregnant if applicable
- ❑ Provider attestation that the requested product will not be used in combination with other denosumab products, bisphosphonates, romosozumab, or parathyroid hormone analogs/related peptides
- ❑ If requesting **Jubbonti® or Stoboclo®,** member must have a documented trial with an inadequate response, or intolerability to **Enoby™**, 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:
  - ❑ Enoby (denosumab-qbde) **AND**
  - ❑ Jubbonti® (denosumab-bbdz) **OR** Stoboclo® (denosumab-bmwo)

❑ Diagnosis: Osteoporosis

Initial Authorization: 6 Months

- ❑ The member is a biological female and post-menopausal
- ❑ The member is at high risk of fracture**
- ❑ Does the member have a documented diagnosis of osteoporosis indicated by **ONE** or more of the following:
  - ❑ T-score by DXA of ≤-2.5 measured at the lumbar spine, femoral neck, total hip, or forearm at the 33% (one-third) radius site; **OR**
  - ❑ History of fragility fracture to the hip or spine, regardless of T-score; **OR**
  - ❑ T-score by DXA between -1.0 and -2.5 measured at the lumbar spine, femoral neck, total hip, or forearm at the 33% (one-third) radius site; **AND**
    - History of fracture of proximal humerus, pelvis, or distal forearm; **OR**
    - FRAX 10-year probability for major fracture ≥ 20% or hip fracture ≥ 3% **AND**
- ❑ The member had a 12-month trial and failure or intolerance* to previous therapy with bisphosphonates (oral or IV) such as alendronate, risedronate, ibandronate, or zoledronic acid

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❑ **Diagnosis: Glucocorticoid – Induced Osteoporosis**

Initial Authorization: 6 Months

- ❑ The member is initiating or continuing systemic glucocorticoid therapy at a daily dosage equivalent to ≥ 2.5 mg of prednisone and is expected to remain on glucocorticoid therapy for at least 3 months
- ❑ The member is at increased risk of fracture***
- ❑ The member had a 12-month trial and failure or intolerance* to previous therapy with bisphosphonates (oral or IV) such as alendronate, risedronate, ibandronate, or zoledronic acid

❑ **Diagnosis: Osteoporosis treatment and prevention in prostate cancer**

Initial Authorization: 6 Months

- ❑ The member is receiving androgen deprivation therapy
- ❑ The member is at high risk for fracture**

❑ **Diagnosis: Osteoporosis treatment and prevention in breast cancer**

Initial Authorization: 6 Months

- ❑ The member is receiving adjuvant aromatase inhibitor therapy for breast cancer
- ❑ The member is at high risk for fracture**

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**

- ❑ 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 and indicates a beneficial response

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***Failed clinical trial is defined as one or more of the following**
• Decrease in T-score in comparison with baseline T-score from DXA scan • Member has a new fracture while on bisphosphonate therapy
****High risk for fractures includes, but are not limited to, one or more of the following:**
• History of osteoporotic fracture as an adult • Parental history of hip fracture • Low BMI • Rheumatoid arthritis • Alcohol intake (3 or more drinks per day) • Current smoking • History of oral glucocorticoids ≥ 5mg/d of prednisone (or equivalent) for >3 months (ever)
***Examples of contraindications to oral biphosphate therapy include the following:**
• Documented inability to sit or stand upright for at least 30 minutes • Documented pre-existing esophageal disorders such as achalasia, esophageal stricture, esophageal varices, or Barrett's esophagus • Surgical anastomoses are present in the GI tract after certain types of bariatric surgery (e.g., Roux-en-Y gastric bypass) • Documented pre-existing hypocalcemia • Documented pre-existing renal insufficiency defined as creatinine clearance < 30-35 mL/min
***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
*****Increased risk for glucocorticoid-induced osteoporosis fractures includes, but are not limited to, one or more of the following:**
• Prior osteoporotic fracture • High-dose glucocorticoid use (i.e., prednisone [or equivalent] ≥ 30 mg/d > 30 d or ≥ 5 g/yr • FRAX glucocorticoid adjusted 10-year risk of major osteoporotic fracture ≥ 20% or hip ≥ 3% • T-score by DXA of < 2.5 measured at the lumbar spine, femoral neck, total hip, or forearm at the 33% (one-third) radius site

Medication being provided by Specialty Pharmacy - PropriumRx

*****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, 6/17/2026,~~ **7.13.2026**