SENTARA HEALTH PLANS

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 1-844-668-1550**. 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 Oncology Indications (MEDICAL)

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.
- Commercial customers **NOT** enrolled in the OncoHealth program, please fax requests to Sentara Health plans at fax number 1-800-750-9692.

Drug Requested: select one drug below

PREFERRED [No Prior Authorization Required]	
❑ **Q5157 Osenvelt**® (denosumab-bmwo)	❑ **Q5136 Wyost**® (denosumab-bbdz)
NON-PREFERRED [Prior Authorization Required]	
❑ **Q5161 Aukelso**™ (denosumab-kyqq)	❑ **Q5165 Oziltus**® (denosumab-mobz)
❑ **Q5162 Bilprevda**® (denosumab-nxxp)	❑ **Q5159 Xbryk**™ (denosumab-dssb)
❑ **Q5158 Bomyntra**® (denosumab-bnht)	❑ **J0897 Xgeva**® (denosumab)
❑ **Q5166 Jubereq**® (denosumab-desu)	❑ **Q5167 Xtrenbo**™ (denosumab-qbde)

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:** _____

❑ 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:

- 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.
- 120 billable units every 4 weeks

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: Oncology**

Initial Authorization: 6 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, Osenvelt® (denosumab-bmwo) **AND** Wyost® (denosumab-bbdz)

Reauthorization: 6 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: Oncology**

❑ The criteria in the initial authorization section has been met: If requesting a non-preferred product, member must have a documented trial with an inadequate response, or intolerability to the preferred biosimilar denosumab products, Osenvelt® (denosumab-bmwo) **AND** Wyost® (denosumab-bbdz)

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

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

For urgent reviews: Practitioner should call Sentara Health Plans Pre-Authorization Department if they believe a standard review would subject the member to adverse health consequences. Sentara Health Plan's 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: ~~12/04/2025;~~ **8/28/2026**