Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Prolia
(denosumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:	* Date of Birth:	
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		

Urgency:
☐ Standard ☐ Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)

Medication requested:
☐ Prolia 60mg ICD10:

Dose: Frequency of therapy: Duration of therapy:

Is this a new start or continuation of therapy? If your patient has already begun treatment with drug samples of Prolia, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

(if osteoporosis and continued therapy) Is there documentation that your patient is having a beneficial clinical response to Prolia? ☐ Yes ☐ No

Where will this medication be obtained?
☐ Accredo Specialty Pharmacy**
☐ Prescriber's office stock (billing on a medical claim form)
☐ Other (please specify):
☐ Retail pharmacy
☐ Home Health / Home Infusion vendor
***Cigna's nationally preferred specialty pharmacy*

***Medication orders can be placed with Accredo via E-prescribe - Accredo (1640 Century Center Pkwy, Memphis, TN 38134-8822 | NCPDP 4436920), Fax 888.302.1028, or Verbal 866.759.1557*

Facility and/or doctor dispensing and administering medication:
Facility Name: State: Tax ID#:
Address (City, State, Zip Code):

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? ☐ Yes ☐ No

Diagnosis related to use:
☐ bone loss in a woman with breast cancer
☐ osteoporosis (osteopenia)
☐ bone loss in prostate cancer
☐ other (please specify):

Clinical Information:

Bisphosphonates include Actonel, alendronate, Binosto, Boniva, etidronate, Fosamax, ibandronate, pamidronate, Reclast, risedronate, Skelid, zoledronic acid. Which of the following best describes your patient?
☐ The patient is NOT taking any bisphosphonates at this time, nor will they in the future.
☐ The patient is currently on a bisphosphonate, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on a bisphosphonate, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND a bisphosphonate.

If bone loss in a woman with breast cancer:
Is your patient currently taking any of the following drugs: anastrozole, Arimidex, Aromasin, exemestane, Femara, letrozole? ☐ Yes ☐ No

(if yes) Is your patient at a high risk for fractures, such as a T-score of -1.0 or lower? ☐ Yes ☐ No

If bone loss in prostate cancer:

Does your patient have metastatic disease? ☐ Yes ☐ No

Is your patient currently receiving androgen deprivation therapy (ADT): Eligard, leuprolide/Lupron/Lupron Depot, Trelstar, Triptodur, Vantas, or Zoladex? ☐ Yes ☐ No

Does your patient have a T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, and/or 33% (one-third) radius [wrist]? ☐ Yes ☐ No

(if no) Does your patient have a history of fragility (non-traumatic) or osteoporotic fracture (typically a fracture of the spine, proximal femur [hip], distal forearm [wrist], or proximal humerus)? ☐ Yes ☐ No

(if no) Does your patient have a T-score between -1.0 and -2.5? ☐ Yes ☐ No

(if yes) Does your patient have either of the following? Note that FRAX information is usually found in the Comment section of the dual energy X-ray absorptiometry (DXA or DEXA) scan.

- ☐ FRAX 10-year probability for major osteoporotic fracture (clinical spine, forearm, hip or shoulder fracture) equal to or greater than 20%
- ☐ FRAX 10-year probability of hip fracture equal to or greater than 3%
- ☐ neither of the above

If osteoporosis:

Does your patient have glucocorticoid-induced osteoporosis (GIO)? ☐ Yes ☐ No

(if GIO) Is your patient starting or continuing treatment with a medium or high dose systemic glucocorticoid (for example, greater than or equal to 7.5mg/day oral prednisone)? ☐ Yes ☐ No

(if yes) Is your patient expected to remain on medium or high dose systemic glucocorticoid for at least 6 months? ☐ Yes ☐ No

(if not GIO) Does your patient have a T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, and/or 33% (one third) radius [wrist? ☐ Yes ☐ No

(if no) Does your patient have a history of fragility (non-traumatic) or osteoporotic fracture (typically a fracture of the spine, proximal femur [hip], distal forearm [wrist], or proximal humerus)? ☐ Yes ☐ No

(if no) Does your patient have a T-score between -1.0 and -2.5? ☐ Yes ☐ No

(if yes) Does your patient have either of the following? Note that FRAX information is usually found in the Comment section of the dual energy X-ray absorptiometry (DXA or DEXA) scan.

- ☐ FRAX 10-year probability for major osteoporotic fracture (clinical spine, forearm, hip or shoulder fracture) equal to or greater than 20%
- ☐ FRAX 10-year probability of hip fracture equal to or greater than 3%
- ☐ neither of the above

(if osteoporosis) Is your patient post-menopausal? ☐ Yes ☐ No

(if osteoporosis) Has your patient tried at least ONE oral OR intravenous bisphosphonate product and had documented failure/inadequate response to it (for example, osteoporotic fracture while receiving bisphosphonate therapy, ongoing loss of BMD or lack of continued BMD increase)?

Notes: Bisphosphonates include:
Oral: alendronate (Fosamax), risedronate (Actonel), and ibandronate (Boniva)
IV: pamidronate, ibandronate and zoledronic acid (Reclast/Zometa) ☐ Yes ☐ No

(if no) Has your patient tried at least ONE oral AND at least ONE intravenous bisphosphonate product and had documented intolerance to both?

Notes: Bisphosphonates include:
Oral: alendronate (Fosamax), risedronate (Actonel), and ibandronate (Boniva)
IV: pamidronate, ibandronate and zoledronic acid (Reclast/Zometa) ☐ Yes ☐ No

(if no) Does your patient have documented contraindication per FDA label, inability to take, or is not a candidate for oral AND intravenous bisphosphonate therapy?

Notes: Bisphosphonates include:
Oral: alendronate (Fosamax), risedronate (Actonel), and ibandronate (Boniva)
IV: pamidronate, ibandronate and zoledronic acid (Reclast/Zometa) ☐ Yes ☐ No

Has your patient previously been treated with any of the following? Check all that apply.

- ☐ an oral bisphosphonate (such as Actonel, Atelvia, alendronate, Binosto, Boniva, etidronate, Fosamax, ibandronate, risedronate)
- ☐ an intravenous (IV) bisphosphonate (such as Boniva, ibandronate, pamidronate, Reclast, zoledronic acid)
- ☐ none of the above

Please provide drug name(s), date(s) taken, and what the documented results were of taking each drug, including any intolerances or adverse reactions your patient experienced.

Additional pertinent information

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature:_____ **Date:**_____

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