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

Aukelso, Bomyntra, Osenvelt, Xbryk, Xgeva, Xtrenbo (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:

☐ Aukleso 120mg
☐ Bomyntra 120mg
☐ Osenvelt 120mg
☐ Xbryk 120mg
☐ Xgeva 120mg
☐ Xtrenbo 120mg

ICD10:

Dose: Frequency of therapy: Duration of therapy:

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 (1620 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 Metastases from Solid Tumors (examples include breast cancer, prostate cancer, and non-small cell lung cancer) – Prevention of Skeletal-Related Events
☐ Giant Cell Tumor of Bone
☐ Hypercalcemia of Malignancy
☐ Multiple Myeloma – Prevention of Skeletal-Related Events
☐ other

Clinical Information:

(if Bone Metastases from Solid Tumors or MM) Is this medication prescribed by, or in consultation with, a hematologist or an oncologist? ☐ Yes ☐ No

(if Bone Metastases from Solid Tumors) Does the patient have bone metastases? ☐ Yes ☐ No

(if Bone Metastases from Solid Tumors) Does the patient have prostate cancer? ☐ Yes ☐ No

(if Bone Metastases from Solid Tumors [prostate cancer]) Is the patient's disease considered to be castration-resistant (meaning it progressed after treatment with hormonal therapy [examples of hormonal therapies for prostate cancer include Lupron Depot (leuprolide for depot suspension), Eligard (leuprolide acetate for injectable suspension), Trelstar (triptorelin pamoate for injectable suspension) or Zoladex (goserelin implant)] or after surgical castration [for example, bilateral orchiectomy])? Yes No

(if Bone Metastases from Solid Tumors or MM) Does the patient have renal impairment (creatinine clearance less than 30 mL/min)? ☐ Yes ☐ No

(if no) Is the patient currently taking, or has a previous history of using denosumab products (Xgeva, biosimilars)? ☐ Yes ☐ No

(if no) Has the patient tried zoledronic acid injection (Zometa)? ☐ Yes ☐ No

(if Hypercalcemia of Malignancy) Does the patient currently have a malignancy? ☐ Yes ☐ No

(if Hypercalcemia of Malignancy) Does the patient have an albumin-corrected calcium (cCa) of 11.5 mg/dL or higher? ☐ Yes ☐ No

If requesting Aukelso, Bomyntra, Osenvelt, Xgeva, or Xtrenbo:

Is documentation being provided that the patient has tried BOTH of the following: Bilprevda and Wyost? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

(if yes) Is documentation being provided that the patient is unable to continue to use the Preferred product due to a formulation difference in the inactive ingredient(s) [for example, difference in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? PLEASE NOTE: Medical documentation specific to your response must be attached to this case or your request may be denied. Documentation may include, but is not limited to, chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information. ☐ Yes ☐ No

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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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