



Fax completed form to: (855) 840-1678

If this is an URGENT request, please call (800) 882-4462
(800.88.CIGNA)

Bilprevda, Wyost (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: ☐ Bilprevda 120mg ☐ Wyost 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 <i>**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</i>					
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

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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