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

Evenity
(romosozumab)

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician's 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: ☐ Evenity 210mg/2.34ml (2 syringe pack) 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 samples, please choose "new start of therapy". ☐ new start of therapy ☐ continuation of therapy

Is the patient currently receiving Evenity? ☐ Yes ☐ No

(if yes) Has the patient received 12 monthly doses or more (during this therapy course)? ☐ Yes ☐ No

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

Where will this drug be administered?
☐ Patient's Home
☐ Hospital Outpatient
☐ Physician's Office
☐ Other (please specify):

***NOTE:** Per some Cigna plans, infusion of medication MUST occur in the least intensive, medically appropriate setting.*

Is this patient a candidate for re-direction to an alternate setting (such as alternate infusion site, physician's office, home) with assistance of a Specialty Care Options Case Manager? ☐ Yes ☐ No (provide medical necessity rationale):

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

What is the indication or diagnosis?

☐ Osteoporosis - Treatment for a postmenopausal patient
☐ Prevention of osteoporosis
☐ All other indications or diagnoses

Clinical Information:

(if treatment) Has the patient had a T-score (current or at any time in the past) at or below -2.5 at the lumbar spine, femoral neck, total hip and/or 33% (one-third) radius (wrist)? ☐ Yes ☐ No

(if no) Does the patient have low bone mass? Please Note: Examples of a low bone mass include a T-score (current or at any time in the past) between -1.0 and -2.5 at the lumbar spine, femoral neck, total hip, and/or 33% (one third) radius (wrist). ☐ Yes ☐ No

(if yes) According to the prescriber, is the patient at high risk for fracture? ☐ Yes ☐ No

(if no low bone mass OR not at high risk for fracture) Has the patient had an osteoporotic fracture or a fragility fracture? ☐ Yes ☐ No

(if treatment) Has the patient tried at least one oral bisphosphonate or oral bisphosphonate-containing product? Please Note: Examples of oral bisphosphonate products include Fosamax (alendronate tablets and oral solution), Fosamax Plus D (alendronate/cholecalciferol tablets), Actonel (risedronate tablets), Atelvia (risedronate delayed-release tablets), Binosto (alendronate effervescent tablets for oral solution), and Boniva (ibandronate tablets). ☐ Yes ☐ No

(if yes) According to the prescriber, has the patient experienced inadequate efficacy to oral bisphosphonate therapy after a trial duration of 12 months? Please Note: Examples of inadequate efficacy are ongoing and significant loss of bone mineral density (BMD), lack of a BMD increase, and/or an osteoporotic fracture or a fragility fracture. ☐ Yes ☐ No

(if no) Did the patient experience significant intolerance to an oral bisphosphonate? Please Note: Examples of significant intolerance include severe gastrointestinal related adverse events, and/or severe musculoskeletal related adverse events. ☐ Yes ☐ No

(if not tried an oral bisphosphonate or bisphosphonate-containing product OR tried but didn't have a significant intolerance) Is the patient unable to take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing? ☐ Yes ☐ No

(if no) Is the patient unable to take an oral bisphosphonate because the patient cannot remain in an upright position after taking an oral bisphosphonate? ☐ Yes ☐ No

(if no) Is the patient unable to take an oral bisphosphonate because the patient has a pre-existing gastrointestinal medical condition? Please Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia). ☐ Yes ☐ No

(if no) Has the patient had an osteoporotic fracture or a fragility fracture? ☐ Yes ☐ No

(if no) According to the prescriber, does the patient have severe renal impairment or chronic kidney disease? Please Note: An example of severe renal impairment is a creatinine clearance less than 35 mL/min. ☐ Yes ☐ No

(if no) Does the patient have a very low T-score less than -3.0? ☐ Yes ☐ No

(if no) Has the patient tried ibandronate intravenous or zoledronic acid intravenous infusion (Reclast)? ☐ Yes ☐ No

(if treatment) With the exception of calcium and/or vitamin D supplements, will the patient be taking this medication in combination with other medications for osteoporosis? Please Note: Examples of medications for osteoporosis that Evenity should NOT be given with include oral bisphosphonates (for example, alendronate, risedronate, ibandronate), intravenous bisphosphonates (zoledronic acid injection [Reclast], intravenous ibandronate), denosumab products (Prolia, biosimilars), teriparatide products (Bonsity, Forteo (generics), Tymlos (abaloparatide subcutaneous injection), and calcitonin nasal spray (Miacalcin/Fortical). ☐ Yes ☐ No

(if treatment) Is the dose prescribed 210 mg administered subcutaneously once every month for no more than 12 monthly doses during a therapy course? ☐ Yes ☐ No

(if treatment) How many monthly doses of Evenity has the patient received in this therapy course?

- ☐ 0 doses
- ☐ 1 dose
- ☐ 2 doses
- ☐ 3 doses
- ☐ 4 doses
- ☐ 5 doses
- ☐ 6 doses
- ☐ 7 doses
- ☐ 8 doses
- ☐ 9 doses
- ☐ 10 doses
- ☐ 11 doses
- ☐ 12 doses

Additional 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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