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 drug samples of Evenity, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy

(if continued therapy) Does your patient have documentation of beneficial response to the requested medication? ☐ Yes ☐ No

(if no) Please provide support for continued use of this medication in your patient.

(if continued therapy) How many monthly doses of Evenity has your patient already received? _____
(if 12 or more doses received) Please provide clinical support as to why your patient requires additional doses of Evenity.

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:
☐ osteoporosis
☐ osteopenia
☐ other (please specify):

Clinical Information:

Has your patient reached menopause? ☐ Yes ☐ No ☐ Not applicable
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]?
(if no) Does your patient have a history of fragility (non-traumatic) 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?

☐ 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 either of the above) Is your patient at high risk for fracture? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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

Will Evenity be used in combination with another osteoporosis agent (like calcitonin, Forteo, Fortical, Miacalcin, Prolia, or Tymlos) NOT including a bisphosphonate? ☐ Yes ☐ No

Additional Information *(including prior therapy, disease stage, performance status, and names/doses/admin schedule of any agents to be used concurrently):*

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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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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