



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:
City:	State:	Zip:	Patient Phone:		
Urgency:					
<input type="checkbox"/> Standard <input type="checkbox"/> 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:					
<input type="checkbox"/> 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". <input type="checkbox"/> new start of therapy <input type="checkbox"/> continued therapy (if osteoporosis and continued therapy) Is there documentation that your patient is having a beneficial clinical response to Prolia? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Where will this medication be obtained?					
<input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Other (please specify): **Cigna's nationally preferred specialty pharmacy					
<small>**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</small>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Diagnosis related to use:					
<input type="checkbox"/> Bone Loss <input type="checkbox"/> Giant Cell Tumor of Bone <input type="checkbox"/> osteoporosis Treatment <input type="checkbox"/> Osteoporosis – Prevention <input type="checkbox"/> other (please specify):					
Clinical Information:					
(if bone loss) Does the patient have BREAST CANCER and is at high risk for fracture due to receiving adjuvant aromatase inhibitor therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					
(if no) Does the patient have nonmetastatic PROSTATE CANCER and is at high risk for fracture due to receiving androgen deprivation therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No					

(if osteoporosis - treatment) Does the patient have glucocorticoid-induced osteoporosis? Yes No

(if not glucocorticoid-induced) Which of the following is your patient?

- Postmenopausal Woman
- Premenopausal Woman
- Man
- None of the above

(if Breast Cancer) Has the patient's breast cancer metastasized to the bones? Yes No

(if Breast Cancer) Is the patient receiving aromatase inhibitor therapy? Yes No

(if Prostate Cancer) Has the patient's prostate cancer metastasized to the bones? Yes No

(if Prostate Cancer) Is the patient receiving androgen deprivation therapy? Yes No

(if no) Has the patient undergone bilateral orchiectomy? Yes No

(if Glucocorticoid) Is the patient either initiating or continuing chronic systemic glucocorticoids? Yes No

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

Has the patient had a bone mineral density (BMD) 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

Notes: T-score between +1 and -1 is considered normal or healthy. T-score between -1 and -2.5 indicates low bone mass. T-score of -2.5 or lower indicates osteoporosis. The greater the negative number, the more severe the osteoporosis.

(if no) Has the patient had a bone mineral density (BMD) 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) Does your patient have either of the following?

Notes: FRAX information is usually found in the Comment section of the dual energy X-ray absorptiometry (DXA or DEXA) scan.

- FRAX (fracture risk assessment tool) 10-year probability for major osteoporotic fracture is at least 20%
- FRAX (fracture risk assessment tool) 10-year probability of hip fracture is at least 3%?
- none of the above

(if Glucocorticoid, Postmenopausal or Man) Has your patient tried at least ONE oral OR intravenous bisphosphonate product and had documented failure/inadequate response to it (Examples of failure/inadequate response include, osteoporotic or fragility fracture while receiving bisphosphonate therapy, ongoing and significant loss of BMD, or lack of a BMD increase)? Yes No

Notes: Bisphosphonates include: a. alendronate tablets or oral solution (Fosamax) b. ibandronate intravenous injection or tablets (Boniva) c. risedronate tablets/delayed release tablets (Actonel/Atelvia) d. zoledronic acid intravenous infusion (Reclast)

(if no) Has your patient tried at least ONE oral AND at least ONE intravenous bisphosphonate product and had documented intolerance to both? 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? Not a candidate due to being subject to a warning per the prescribing information (labeling), having a disease characteristic, individual clinical factor[s], or other attributes/conditions or is unable to administer and requires this dosage formulation Yes No

(if no) Which of the following describes the patient?

- recent fracture within past 12 months
- fractures while on approved osteoporosis therapy
- multiple fractures
- fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids)
- very low T-score (e.g., less than - 3.0)
- high risk for falls or history of injurious falls
- very high fracture probability by FRAX (fracture risk assessment tool) (e.g., major osteoporosis fracture at least 30%, hip fracture at least 4.5%)
- MORE THAN ONE of the above
- NONE of the above or Unknown

Will Prolia be used concurrently with any other medications for osteoporosis? Examples include teriparatide subcutaneous injection (Forteo), Tymlos (abaloparatide subcutaneous injection), oral bisphosphonates (for example, alendronate, risedronate, ibandronate), intravenous bisphosphonates (zoledronic acid intravenous infusion [Reclast], ibandronate intravenous infusion), calcitonin nasal spray (Miacalcin/Fortal), and Evenity (romosozumab-aqq subcutaneous injection). 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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