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

Xgeva
(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: ☐ Xgeva 120mg 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 Xgeva, please choose "new start of therapy". ☐ new start of therapy ☐ continued therapy
(if continued therapy) Has your patient had a beneficial clinical response to Xgeva? ☐ Yes ☐ No

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:
☐ giant cell tumor of the bone (GCTB)
☐ hypercalcemia of malignancy (cancer associated hypercalcemia)
☐ other (please specify):
☐ multiple myeloma
☐ solid tumor with bone metastases

Clinical Information:

Bisphosphonates include Actonel, alendronate, Binosto, Boniva, etidronate, Fosamax, ibandronate, pamidronate, Reclast, risedronate, Skelid, zoledronic acid. Which of the following best describes your patient?
☐ The patient is NOT taking any bisphosphonates at this time, nor will they in the future.
☐ The patient is currently on a bisphosphonate, but this drug will be stopped and the requested drug will be started.
☐ The patient is currently on a bisphosphonate, and the requested drug will be added. The patient may continue to take both drugs together.
☐ The patient is currently on BOTH the requested drug AND a bisphosphonate.

If hypercalcemia:
Did your patient have failure to an intravenous (IV) bisphosphonate (such as Boniva, ibandronate, pamidronate, zoledronic acid, Zometa)? ☐ Yes ☐ No

If multiple myeloma:
Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for zoledronic acid (Zometa)? ☐ Yes ☐ No
Is Xgeva being used for the prevention of skeletal-related events (SREs): pathologic fracture, spinal cord compression (SCC), the need for radiation (for pain or impending fracture) or surgery to bone? ☐ Yes ☐ No

If solid tumor:
Is there documentation that your patient either has had failure, inadequate response or intolerance OR has a contraindication per FDA label OR is not a candidate for zoledronic acid (Zometa)? ☐ Yes ☐ No
Is Xgeva being used for the prevention of skeletal-related events (SREs): pathologic fracture, spinal cord compression (SCC), the need for radiation (for pain or impending fracture) or surgery to bone? ☐ Yes ☐ No

What is the primary cancer type? ☐ breast cancer ☐ prostate cancer ☐ other
(if breast cancer) Does your patient have a life expectancy of at least 3 months? ☐ Yes ☐ No
(if prostate cancer) Has your patient had an orchiectomy? ☐ Yes ☐ No
(if no) Has your patient previously tried hormone therapy, such as Eligard, leuprolide/Lupron/Lupron Depot, Trelstar, Triptodur, Vantas, or Zoladex? ☐ Yes ☐ No
(if orchiectomy or hormones) Did your patient initially respond to treatment and is no longer responding? ☐ Yes ☐ No

If GCTB:
(if pt is age 12-18) Are your patient's epiphyses open or closed? ☐ closed ☐ open

Does your patient have localized, diffuse or metastatic disease? ☐ localized ☐ diffuse ☐ metastatic
(if localized) Will Xgeva be used as single agent therapy OR in combination with interferon alfa (Intron A) or radiation therapy? ☐ Yes ☐ No
(if metastatic) Will Xgeva be used as single agent therapy? ☐ Yes ☐ No

Additional pertinent 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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