



Fax completed form to: (855) 840-1678

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

Bilprevda, Jubereq, 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 ☐ Jubereq 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): 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 your patient a candidate for home infusion? ☐ Yes ☐ No Does the physician have an in-office infusion site? ☐ Yes ☐ No 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 - Prevention of Skeletal-Related Events; Note: Some examples of cancer in this clinical scenario include breast cancer, kidney cancer, prostate cancer, non-small cell lung cancer, and thyroid carcinoma.
- ☐ Giant Cell Tumor of Bone
- ☐ Hypercalcemia of Malignancy
- ☐ Multiple Myeloma – Prevention of Skeletal-Related Events
- ☐ Other

Clinical Information:

Will the requested medication be used concurrently with other denosumab products? Please Note: Examples of other denosumab products include Prolia, biosimilars. ☐ Yes ☐ No

(if Bone Metastases from Solid Tumors or MM) Will the requested medication be prescribed by, or in consultation with, a hematologist or an oncologist? ☐ Yes ☐ No

(if Bone Metastases from Solid Tumors or MM) Does the patient have bone metastases? ☐ Yes ☐ No

(if Bone Metastases from Solid Tumors or MM) 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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