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:	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:

☐ 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". ☐ new start of therapy ☐ continued therapy

(if osteoporosis and continued therapy) Is there documentation that your patient is having a beneficial clinical response to Prolia? ☐ 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 (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):

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 Bone
☐ Osteoporosis PREVENTION
☐ Bone Loss (Treatment to Increase Bone Mass) in Individuals with Nonmetastatic BREAST CANCER at High Risk for Fracture Receiving Adjuvant Aromatase Inhibitor Therapy
☐ Increase Bone Mineral Density in Patients with BREAST CANCER
☐ Bone Loss (Treatment to Increase Bone Mass) in Individuals with Nonmetastatic PROSTATE CANCER at High Risk for Fracture Receiving Androgen Deprivation Therapy
☐ Treatment of Bone Loss in Patients with PROSTATE CANCER Receiving Androgen Deprivation Therapy
☐ GLUCOCORTICOID-Induced Osteoporosis – Treatment
☐ Treatment of osteoporosis (patient does NOT meet any of the situations above)
☐ other (please specify):

Clinical Information:

(if Treatment of osteoporosis [patient does NOT meet any of the situations above]) Which of the following is your patient?
☐ Postmenopausal Woman
☐ Premenopausal Woman
☐ Man
☐ None of the above

(if Bone Loss [Treatment to Increase Bone Mass] in Individuals with Nonmetastatic BREAST CANCER at High Risk for Fracture Receiving Adjuvant Aromatase Inhibitor Therapy) Has the patient's breast cancer metastasized to the bones? ☐ Yes ☐ No

(if Bone Loss [Treatment to Increase Bone Mass] in Individuals with Nonmetastatic BREAST CANCER at High Risk for Fracture Receiving Adjuvant Aromatase Inhibitor Therapy) Is the patient receiving aromatase inhibitor therapy? ☐ Yes ☐ No

(if Bone Loss [Treatment to Increase Bone Mass] in Individuals with Nonmetastatic PROSTATE CANCER at High Risk for Fracture Receiving Androgen Deprivation Therapy) Has the patient's prostate cancer metastasized to the bones? ☐ Yes ☐ No

(if Bone Loss [Treatment to Increase Bone Mass] in Individuals with Nonmetastatic PROSTATE CANCER at High Risk for Fracture Receiving Androgen Deprivation Therapy) 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 POST menopausal WOMAN 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)?
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. ☐ Yes ☐ No

(if no) Does the patient have low bone mass (for example, 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])?
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.
☐ 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 WOMAN or MAN) Has your patient tried at least ONE oral OR intravenous bisphosphonate product and had 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)?
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) ☐ Yes ☐ No

(if no) Has your patient tried at least ONE oral AND at least ONE intravenous bisphosphonate product and had intolerance to both?
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) ☐ Yes ☐ No

(if no) Is your patient unable to try either oral or intravenous bisphosphonate therapy because of a contraindication to BOTH of these drugs?
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) ☐ Yes ☐ No

(if no) Which of the following describe 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

(if Increase Bone Mineral Density in Patients with BREAST CANCER) Which of the following is your patient?
☐ Postmenopausal
☐ Premenopausal

(if Postmenopausal) Is the patient receiving aromatase inhibitor therapy? Note: Examples of aromatase inhibitor therapy are anastrozole, letrozole, or exemestane. ☐ Yes ☐ No

(if Premenopausal) Is the patient receiving estrogen deprivation therapy? Note: Examples of estrogen deprivation therapy are leuprolide acetate, Lupron Depot (leuprolide acetate intramuscular injection), Trelstar (triptorelin pamoate intramuscular injection), Zoladex (goserelin acetate subcutaneous injection), anastrozole, letrozole, and exemestane. ☐ Yes ☐ No

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/Fortical), and Evenity (romosozumab-aqqg subcutaneous injection)]? ☐ Yes ☐ No

Additional pertinent information: *Please provide any additional pertinent clinical information, including: if the patient is currently on the requested drug (with dates of use) and how they have been receiving it (for example: samples, out of pocket).*

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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