



Fax completed form to: (855) 840-1678

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

Bomyntra, Osenvelt, Wyost, 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: <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"/> Bomyntra 120mg <input type="checkbox"/> Osenvelt 120mg <input type="checkbox"/> Wyost 120mg <input type="checkbox"/> Xgeva 120mg				
ICD10:				
Dose:	Frequency of therapy:		Duration of therapy:	
Where will this medication be obtained? <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Prescriber's office stock (billing on a medical claim form) <input type="checkbox"/> Other (please specify):				
			<input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Home Health / Home Infusion vendor <i>**Cigna's nationally preferred specialty pharmacy</i>	
<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):				
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 Metastases from Solid Tumors (examples include breast cancer, prostate cancer, and non-small cell lung cancer) – Prevention of Skeletal-Related Events <input type="checkbox"/> Giant Cell Tumor of Bone <input type="checkbox"/> Hypercalcemia of Malignancy <input type="checkbox"/> Multiple Myeloma – Prevention of Skeletal-Related Events <input type="checkbox"/> other				
Clinical Information:				
(if Bone Metastases from Solid Tumors or MM) Is this medication prescribed by, or in consultation with, a hematologist or an oncologist? <input type="checkbox"/> Yes <input type="checkbox"/> No				
(if Bone Metastases from Solid Tumors) Does the patient have bone metastases? <input type="checkbox"/> Yes <input type="checkbox"/> No				
(if Bone Metastases from Solid Tumors) Does the patient have prostate cancer? <input type="checkbox"/> Yes <input type="checkbox"/> 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)])? 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

If requesting Bomynta or Osenvelt:

Has the patient tried Wyost and Xgeva? Yes No

(if yes) Is the patient unable to continue to use each of the formulary alternative(s) due to a formulation difference in the inactive ingredient(s) [for example, differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction? 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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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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