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

# Evenity
## (romosozumab)

| PHYSICIAN INFORMATION | | | PATIENT INFORMATION | | |
|---|---|---|---|---|---|
| * Physician's 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:** ☐ Evenity 210mg/2.34ml (2 syringe pack) 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 samples, please choose "new start of therapy". ☐ new start of therapy ☐ continuation of therapy

(if continued therapy) How many monthly doses of this medication has your patient already received? _____

(if continued therapy) Has your patient already received 12 or more monthly doses of this medication? ☐ Yes ☐ No

(if yes) Please provide clinical support as to why your patient requires additional doses of this medication. _____

**Where will this medication be obtained?**
☐ Accredo Specialty Pharmacy**
☐ Hospital Outpatient
☐ Retail pharmacy
☐ Other (please specify):
☐ Home Health / Home Infusion vendor
☐ Physician's office stock (billing on a medical claim form)
***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):

**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 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

**Clinical Information:**

How is this medication being used?
☐ Osteoporosis Treatment
☐ Osteoporosis Prevention
☐ Other

(if other) What is the diagnosis related to use? _____

Is the patient a postmenopausal woman (a female who reached menopause)? ☐ Yes ☐ No ☐ Not applicable

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)?
Note: 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) 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

Has your patient tried at least ONE oral OR intravenous bisphosphonate product and had failure or 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)?
Note: 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 both an oral AND intravenous bisphosphonate product and had a significant intolerance to both?
☐ Yes ☐ No

(if no) Does your patient have a contraindication to both oral AND intravenous bisphosphonate therapy? ☐ Yes ☐ No

(if no) Is the patient at very high risk for fracture? Examples include, 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, and very high fracture probability by FRAX (fracture risk assessment tool) (e.g., major osteoporosis fracture at least 30%, hip fracture at least 4.5%) ☐ Yes ☐ No

Will this medication be used concurrently with any other medications for osteoporosis (calcitonin, Forteo [teriparatide], Fortical, Miacalcin, Prolia, Tymlos, or bisphosphonates [Fosamax, Actonel, Boniva, Reclast/Zometa])? ☐ Yes ☐ No

**Additional 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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