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

Tymlos
(abaloparatide)

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: ☐ Tymlos 80 mcg/dose prefilled pen

Dose: Frequency of therapy: Duration of therapy: ICD10:

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

Clinical Information:
Which of the following is Tymlos being used to treat?
☐ osteoporosis
☐ osteopenia
☐ other (please specify):

Has your patient reached menopause?
☐ Yes
☐ No
☐ Not applicable

Does your patient have any of the following: history of osteoporotic fracture, multiple risk factors for fracture, failure or intolerance to other available osteoporosis therapy? ☐ Yes ☐ No
Does your patient have a T score of -2.5 or lower? ☐ Yes ☐ No
(if no) Does your patient have a history of fragility (non-traumatic) fracture (typically a fracture of the spine, proximal femur [hip], distal forearm [wrist], or proximal humerus)? ☐ Yes ☐ No
(if no) Does your patient have a T score between -1.0 and -2.5? ☐ Yes ☐ No
(if yes) Does your patient have a FRAX 10-year probability for major osteoporotic fracture of 20% or higher OR is the 10-year probability of hip fracture 3% or higher? ☐ 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:**_____

Save Time! Submit Online at: www.covermymeds.com/main/prior-authorization-forms/cigna/ or via SureScripts in your EHR.

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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