



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:		
<b>Urgency:</b> <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)					
<b>Medication requested:</b> <input type="checkbox"/> Evenity 210mg/2.34ml (2 syringe pack) <span style="float: right;">ICD10:</span> 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". <input type="checkbox"/> new start of therapy <input type="checkbox"/> continuation of therapy Is the patient currently receiving Evenity? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> (if yes) Has the patient received 12 monthly doses or more (during this therapy course)? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>					
<b>Where will this medication be obtained?</b> <input type="checkbox"/> Accredo Specialty Pharmacy** <input type="checkbox"/> Home Health / Home Infusion vendor <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Physician's office stock (billing on a medical claim form) <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> Other (please specify): <b>**Cigna's nationally preferred specialty pharmacy</b> <b>**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</b>					
<b>Facility and/or doctor dispensing and administering medication:</b> Facility Name: _____ State: _____ Tax ID#: _____ Address (City, State, Zip Code): _____					
<b>Where will this drug be administered?</b> <input type="checkbox"/> Patient's Home <input type="checkbox"/> Physician's Office <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Other (please specify): _____					
<b>NOTE:</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:

### What is the indication or diagnosis?

- Treatment of postmenopausal patients with osteoporosis  
 Prevention of osteoporosis  
 All other indications or diagnoses

(if treatment) Has the patient had a 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)?  Yes  No

(if no) Does the patient have low bone mass? Please Note: Examples of a low bone mass include 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).

(if yes) According to the prescriber, is the patient at high risk for fracture?

(if no low bone mass OR not at high risk for fracture) Has the patient had an osteoporotic fracture or a fragility fracture?

(if treatment) Has the patient tried at least one oral bisphosphonate or oral bisphosphonate-containing product? Please Note: Examples of oral bisphosphonate products include Fosamax (alendronate tablets and oral solution), Fosamax Plus D (alendronate/cholecalciferol tablets), Actonel (risedronate tablets), Atelvia (risedronate delayed-release tablets), Binosto (alendronate effervescent tablets for oral solution), and Boniva (ibandronate tablets).

(if yes) According to the prescriber, has the patient experienced inadequate efficacy to oral bisphosphonate therapy after a trial duration of 12 months? Please Note: Examples of inadequate efficacy are ongoing and significant loss of bone mineral density (BMD), lack of a BMD increase, and/or an osteoporotic fracture or a fragility fracture.

(if no) Did the patient experience significant intolerance to an oral bisphosphonate? Please Note: Examples of significant intolerance include severe gastrointestinal related adverse events, severe musculoskeletal related adverse events, or a femoral fracture.

(if not tried an oral bisphosphonate or bisphosphonate-containing product OR tried but didn't have a significant intolerance) Is the patient unable to take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing?

(if no) Is the patient unable to take an oral bisphosphonate because the patient cannot remain in an upright position after taking an oral bisphosphonate?

(if no) Is the patient unable to take an oral bisphosphonate because the patient has a pre-existing gastrointestinal medical condition? Please Note: Examples of pre-existing gastrointestinal medical conditions include esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying (stricture, achalasia).

(if no) Has the patient had an osteoporotic fracture or a fragility fracture?

(if no) According to the prescriber, does the patient have severe renal impairment or chronic kidney disease? Please Note: An example of severe renal impairment is a creatinine clearance less than 35 mL/min.

(if no) Has the patient tried ibandronate injection (Boniva) or zoledronic acid injection (Reclast)?

(if treatment) With the exception of calcium and/or vitamin D supplements, will the patient be taking this medication in combination with other medications for osteoporosis? Please Note: Examples of medications for osteoporosis that Evenity should NOT be given with include oral bisphosphonates (for example, alendronate, risedronate, ibandronate), intravenous bisphosphonates (zoledronic acid injection [Reclast], intravenous ibandronate), Prolia (denosumab subcutaneous injection), Forteo (teriparatide subcutaneous injection generic), Tymlos (abaloparatide subcutaneous injection), and calcitonin nasal spray (Miacalcin/Fortical).

(if treatment) Is the dose prescribed 210 mg administered subcutaneously once every month for no more than 12 monthly doses during a therapy course?

(if treatment) How many monthly doses of Evenity has the patient received in this therapy course?

- 0 doses
- 1 dose
- 2 doses
- 3 doses
- 4 doses
- 5 doses
- 6 doses
- 7 doses
- 8 doses
- 9 doses
- 10 doses
- 11 doses
- 12 doses

**Additional 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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