

MEDICARE FORM

Evenity® (romosozumab-aqqg) Injectable Medication Precertification Request

Page 1 of 2 Note: Evenity is non-preferred. (All fields must be completed and legible for precertification review.) The preferred products for MA plans are Prolia and IV zoledronic acid. Please indicate: Start of treatment: Start date / The preferred product for MAPD ☐ Continuation of therapy: Date of last treatment / / plans is Forteo. Phone: __ Precertification Requested By: Fax: A. PATIENT INFORMATION First Name: Last Name: Address: City: State: ZIP: Home Phone: Work Phone: Cell Phone: DOB: E-mail: Allergies: Current Weight: kgs Height: _ inches or lbs or cms B. INSURANCE INFORMATION Does patient have other coverage? ☐ Yes ☐ No Aetna Member ID #: If yes, provide ID#: Carrier Name: Group #: _____ Insured: Insured: C. PRESCRIBER INFORMATION First Name: Last Name: (Check One): M.D. D.O. N.P. P.A. ZIP: Address: City: NPI#: Phone: Fax: St Lic #: DEA #: UPIN: Provider Email: Office Contact Name: Phone: D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION Place of Administration: Dispensing Provider/Pharmacy: ☐ Self-administered ☐ Physician's Office ☐ Physician's Office ☐ Retail Pharmacy ☐ Outpatient Infusion Center ☐ Specialty Pharmacy ☐ Other _____ Center Name: Name: Phone: ☐ Home Infusion Center Agency Name: _ City: _____ State: ____ ZIP: ____ Administration code(s) (CPT): Address: City: _____ State: ____ ZIP: ____ TIN: _____ PIN: ____ Phone: ____ _____ Fax: _____ _ PIN: _____ TIN: _____ E. PRODUCT INFORMATION Request is for: Evenity® (romosozumab-aqqg): Dose: HCPCS Code: Frequency: F. DIAGNOSIS INFORMATION - Please indicate primary ICD Code and specify any other where applicable. Primary ICD Code: Secondary ICD Code: Other ICD Code: G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests. For Initiation Requests (clinical documentation required for all requests): Note: Evenity is non-preferred. The preferred products for MA plans are Prolia and IV zoledronic acid. The preferred product for MAPD plans is Forteo. ☐ Yes ☐ No Has the patient had prior therapy with Evenity (romosozumab-aqqg) within the last 365 days? ☐ Yes ☐ No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply) ☐ Prolia (denosumab) ☐ IV zoledronic acid Yes No Has the patient had a trial and failure, intolerance, or contraindication to any of the following? (select all that apply) ☐ Forteo (teriparatide) Yes No Has the patient completed two years of treatment with a parathyroid hormone medication? Please explain if there are any medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis (select all that apply). ☐ Prolia (denosumab) ☐ IV zoledronic acid

Please explain if there are any medical reason(s) that the patient cannot use any of the following preferred products when indicated for the patient's diagnosis

For New Jersey HMO D-SNP:

For other lines of business:

FAX: 1-833-322-0034 **PHONE:** 1-844-362-0934

Please use other form.

(select all that apply).

☐ Forteo (teriparatide)



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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
G. CLINICAL INFORMATION (continued) - Required clinical information must be completed in its entirety for all precertification requests.			
Please explain if there are any medical reason(s) that the patient cannot use Forteo (teriparatide):			
Please provide the patient's Bone Mineral Densit	ty (BMD) score and date obtained: T-score:	:	Date: /
Please indicate the location the BMD was measured: 🗌 femoral neck 🔲 lumbar spine 🗎 total hip 🔲 other: please identify:			
☐ Yes ☐ No Is the patient receiving 1000mg of calcium and 400 international units of vitamin D daily?			
Yes No Does the patient have clinical evidence of uncorrected preexisting hypocalcemia?			
☐ Yes ☐ No Is the patient at high risk for fractures?			
☐ Yes ☐ No Has the patient had an osteoporotic fracture? ☐ Yes ☐ No Does the patient have multiple risk factors for fractures?			
Please explain (select all that apply): alcohol intake of 4 or more units per day parental history of hip fracture			
☐ rheumatoid arthritis ☐ current tobacco smoking ☐ none of the above			
For All Requests:			
Post-menopausal osteoporosis			
☐ Yes ☐ No Is there documentation that the trial of 2 oral and/or injectable bisphosphonates was ineffective?			
Yes No Is there documentation that a trial of 1 bisphosphonate AND 1 selective estrogen receptor modulator (SERM) was ineffective?			
Please identify the failure of the medication trial: Continued bone loss Other: please identify: Other: please identify:			
Bisphosphonate #1 Date range:// Bisphosphonate #2 OR SERM Date range:////			
Sisphosphonate #2 OR SERM Date range: / / / / Yes			
Select all that apply: bisphosphonates SERM			
☐ Yes ☐ No Is there documented evidence that the patient has a contraindication to bisphosphonates and/or SERMs?			
Select all that apply: bisphosphonates SERM			
Please select which of the following bisphosphonates and/or SERM's was ineffective, not tolerated or contraindicated:			
Select all that apply: Alendronate (Binosto, Fosamax or Fosamax plus D)			
☐ Risedronate (Actonel, Actonel with Calcium or Atelvia) ☐ Tiludronate (Skelid) ☐ Zoledronic acid (Zometa, Reclast)			
Raloxifene (Evista) Tamoxifen (Nolvadex/Soltamox) Toremifene citrate (Fareston) Other: Please identify:			
For Continuation Requests: (Clinical documentation required for all requests)			
Yes No Does the patient have a hypersensitivity to romosozumab-aqqg?			
Please indicate what type of response the patient has experienced while on romosozumab-aqqg: No response Minimal response Adequate response Significant improvement			
		☐ Adequate response ☐	_ Significant improvement
H. ACKNOWLEDGEMENT			
Request Completed By (Signature Require	rd):		Date:/
Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.			

The plan may request additional information or clarification, if needed, to evaluate requests.