MEDICARE FORM
Evenity® (romosozumab-aqqg) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

For Medicare Advantage Part B:
FAX: 1-844-268-7263
PHONE: 1-866-503-0857

For other lines of business:
Please use other form.

Note: Evenity is non-preferred. The preferred product for MA plans is Prolia. The preferred product for MAPD plans is Forteo.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	E-mail:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Office Contact Name:				Phone:	

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy:
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Evenity® (romosozumab-aqqg): Dose: _____ **Frequency:** _____ **HCPCS Code:** _____

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 product for MA plans is Prolia. 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, intolerance, or contraindication to Prolia (denosumab)?
☐ Yes ☐ No Has the patient had a trial, intolerance, or contraindication to Forteo (teriparatide)?
Please explain if there are any medical reason(s) that the patient cannot use Prolia (denosumab): _____
Please explain if there are any medical reason(s) that the patient cannot use Forteo (teriparatide): _____

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: _____
Bisphosphonate #1 Date range: ____/____/____ - ____/____/____
Bisphosphonate #2 OR SERM Date range: ____/____/____ - ____/____/____

☐ Yes ☐ No Is there documented evidence that the patient has an intolerance to bisphosphonates and/or SERMs?
→ 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) ☐ Etidronate disodium (Didronel) ☐ Ibandronate (Boniva)
☐ Risedronate (Actonel, Actonel with Calcium or Atelvia) ☐ Tiludronate (Skelid) ☐ Zoledronic acid (Zometa, Reclast)
☐ Raloxifene (Evista) ☐ Tamoxifen (Nolvadex/Soltamox) ☐ Toremifene citrate (Fareston) ☐ Other: Please identify: _____

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aetna™

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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.

Prevention or treatment of osteoporosis in patients receiving aromatase inhibitors

☐ Yes ☐ No Is the patient receiving aromatase inhibitors?
→ Please indicate which of the following aromatase inhibitors is being used:
☐ anastrozole (Arimidex) ☐ exemestane (Aromasin) ☐ letrozole (Femara) ☐ Other: please identify: _____

☐ Yes ☐ No Is there documentation that the trial of oral and/or injectable bisphosphonates was ineffective?
→ Please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____
Bisphosphonate #1 Date range: ____/____/____ - ____/____/____
Bisphosphonate #2 Date range: ____/____/____ - ____/____/____

☐ Yes ☐ No Is there documented evidence that the patient has an intolerance to bisphosphonates?
☐ Yes ☐ No Is there documented evidence that the patient has a contraindication to bisphosphonates?
Please select which of the following bisphosphonates was ineffective, not tolerated or contraindicated:
Select all that apply: ☐ Alendronate (Binosto, Fosamax or Fosamax plus D) ☐ Etidronate disodium (Didronel) ☐ Ibandronate (Boniva)
☐ Risedronate (Actonel, Actonel with Calcium or Atelvia) ☐ Tiludronate (Skelid) ☐ Zoledronic acid (Zometa, Reclast)
☐ Other: Please identify: _____

Treatment to increase bone mass in men receiving androgen deprivation therapy

☐ Yes ☐ No Does the patient have prostate cancer?
☐ Yes ☐ No Is the patient receiving androgen deprivation therapy?

Treatment of bone loss in men with osteoporosis

☐ Yes ☐ No Is there documentation that the trial of oral and/or injectable bisphosphonates was ineffective?
→ Please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____
Bisphosphonate #1 Date range: ____/____/____ - ____/____/____
Bisphosphonate #2 Date range: ____/____/____ - ____/____/____

☐ Yes ☐ No Is there documented evidence that the patient has an intolerance to bisphosphonates?
☐ Yes ☐ No Is there documented evidence that the patient has a contraindication to bisphosphonates?
Please select which of the following bisphosphonates was ineffective, not tolerated or contraindicated:
Select all that apply: ☐ Alendronate (Binosto, Fosamax or Fosamax plus D) ☐ Etidronate disodium (Didronel) ☐ Ibandronate (Boniva)
☐ Risedronate (Actonel, Actonel with Calcium or Atelvia) ☐ Tiludronate (Skelid) ☐ Zoledronic acid (Zometa, Reclast)
☐ Other: Please identify: _____

Treatment of glucocorticoid-induced osteoporosis

☐ Yes ☐ No Is the patient initiating or continuing systemic glucocorticoids at a daily dosage equivalent to 7.5 mg or greater of prednisone?
→ Please select: ☐ initiating systemic glucocorticoids ☐ continuing systemic glucocorticoids
☐ Yes ☐ No Is the patient expected to remain on glucocorticoids for at least 6 months?

☐ Yes ☐ No Is there documentation that the trial of oral and/or injectable bisphosphonates was ineffective?
→ Please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____
Bisphosphonate #1 Date range: ____/____/____ - ____/____/____
Bisphosphonate #2 Date range: ____/____/____ - ____/____/____

☐ Yes ☐ No Is there documented evidence that the patient has an intolerance to bisphosphonates?
☐ Yes ☐ No Is there documented evidence that the patient has a contraindication to bisphosphonates?
Please select which of the following bisphosphonates was ineffective, not tolerated or contraindicated:
Select all that apply: ☐ Alendronate (Binosto, Fosamax or Fosamax plus D) ☐ Etidronate disodium (Didronel) ☐ Ibandronate (Boniva)
☐ Risedronate (Actonel, Actonel with Calcium or Atelvia) ☐ Tiludronate (Skelid) ☐ Zoledronic acid (Zometa, Reclast)
☐ 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

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **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.