Miacalcin® (calcitonin) Medication Precertification Request

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

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

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

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: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

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:
Provider E-mail:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **Gynecologist** ☐ **Internal Medicine** ☐ **Hematologist** ☐ **Endocrinologist** ☐ **Other**: _____

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: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: Miacalcin (calcitonin) Dose: _____ **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):

Hypercalcemia
☐ Yes ☐ No Does the patient have a diagnosis of hypercalcemia?

Management of pain following an osteoporotic vertebral fracture
☐ Yes ☐ No Does the patient have a diagnosis of osteoporosis?
☐ Yes ☐ No Has the osteoporotic spinal compression fracture been verified on imaging with the correlating clinical signs and symptoms suggesting an acute injury?
→ Please indicate date of event or onset of symptoms: ____/____/____
Please indicate date of imaging: ____/____/____ (*Imaging report must be submitted for review)*
☐ Yes ☐ No Has the patient had an ineffective response, intolerance, or contraindication to standard analgesic therapy (e.g., non-steroidal anti-inflammatory drug (NSAID), acetaminophen)?
☐ Yes ☐ No Has the patient had an intolerance or contraindication to intranasal calcitonin?
☐ Yes ☐ No ☐ Unknown Is the patient neurologically intact?

Paget's disease of bone
☐ Yes ☐ No Does the patient have symptoms of Paget's disease of bone (e.g., bone pain, bone deformity, fracture, hearing loss)?
☐ Yes ☐ No Has the patient failed prior treatment with an injectable bisphosphonate (e.g., pamidronate, Reclast (zoledronic acid)) or experienced intolerance to a previous injectable bisphosphonate?

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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.

Postmenopausal osteoporosis

☐ Yes ☐ No Is the patient greater than 5 years post-menopause?

☐ Yes ☐ No Does the patient have a history of fragility fractures?

→ Please indicate the patient's pre-treatment T-score:

☐ -2.5 or below (e.g., -2.6, -2.7, -3) ☐ Osteopenia [between -2.5 and -1 (e.g., -2.4, -2.3, -2)] ☐ -1 or above (e.g., -0.9, -0.8, -0.5) ☐ unknown

Please indicate the patient's pre-treatment FRAX score for any major fracture: ☐ less than 20% ☐ greater than or equal to 20% ☐ unknown

Please indicate the patient's pre-treatment FRAX score for hip fracture: ☐ less than 3% ☐ greater than or equal to 3% ☐ unknown

☐ Yes ☐ No Has the patient failed prior treatment of an oral bisphosphonate?

→ ☐ Yes ☐ No Is there a clinical reason to avoid treatment with a bisphosphonate?

→ Please indicate clinical reason:

- ☐ presence of anatomic or functional esophageal abnormalities that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility)
- ☐ active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers)
- ☐ presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders, etc.)
- ☐ inability to stand or sit upright for 30 to 60 minutes
- ☐ inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day
- ☐ renal insufficiency (creatinine clearance less than 35 ml/min)
- ☐ history of intolerance to an oral bisphosphonate
- ☐ no clinical reason to avoid treatment with an oral bisphosphonate
- ☐ other, please explain: _____

☐ Yes ☐ No Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo, Bonsity], denosumab [Prolia], abaloparatide [Tymlos])?

☐ Yes ☐ No Has the patient had an intolerance or contraindication to intranasal calcitonin?

For Continuation Requests (clinical documentation required):

Hypercalcemia

☐ Yes ☐ No Has the patient experienced benefit from therapy as evidenced by disease stability or disease improvement?

☐ Yes ☐ No Has the patient experienced any adverse effects?

Management of pain following an osteoporotic vertebral fracture

☐ Yes ☐ No Does the patient have a diagnosis of osteoporosis?

☐ Yes ☐ No Has the osteoporotic spinal compression fracture been verified on imaging with the correlating clinical signs and symptoms suggesting an acute injury?

→ Please indicate date of event or onset of symptoms: ____/____/____

Please indicate date of imaging: ____/____/____ (*Imaging report must be submitted for review)*

☐ Yes ☐ No Has the patient had an ineffective response, intolerance, or contraindication to standard analgesic therapy (e.g., non-steroidal anti-inflammatory drug (NSAID), acetaminophen)?

☐ Yes ☐ No Has the patient had an intolerance or contraindication to intranasal calcitonin?

☐ Yes ☐ No ☐ Unknown Is the patient neurologically intact?

Paget's disease of bone

☐ Yes ☐ No Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program?

☐ Yes ☐ No Has the patient experienced benefit from therapy as evidence by disease stability or disease improvement?

☐ Yes ☐ No Has the patient experienced any adverse effects?

Postmenopausal osteoporosis

☐ Yes ☐ No Is the patient currently receiving the requested medication through samples or a manufacturer's patient assistance program?

Please indicate the length of time on therapy:

☐ Less than 24 months

→ ☐ Yes ☐ No Is the patient experiencing clinical benefit as evidenced by no adverse events during therapy (i.e., no clinically significant adverse reaction, no new fracture seen on radiography)?

☐ 24 months or greater

→ ☐ Yes ☐ No Has the patient experienced clinical benefit as evidenced by a bone mass measurement showing an improvement or stabilization in T-score compared with the previous bone mass measurement?

☐ Yes ☐ No Has the patient experienced any adverse effects?

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.