MEDICARE FORM

Evenity® (romosozumab-aqqg) Injectable Medication Precertification Request

(All fields must be completed and legible for precertification review.)

For Medicare Advantage Part B:
For other lines of business:
Please use commercial form.

Note: Evenity is non-preferred. The preferred products is IV zoledronic acid followed by Jubbonti or Prolia as secondary preferred products.

Would you like to use electronic prior authorization? Consider using **Availity**, our electronic prior authorization portal. Learn more about **Availity** from the links in the table below.

For phone or fax requests, refer to the table below for routing information. To determine which box to use, refer to the patient's Aetna ID card. State specific special needs and Medicare-Medicaid Plans may be designated on the front of the ID card or in the website URL on the back of the card. If you don't see your specific plan listed, call the number on the back of the member's ID card to confirm routing information.

For Aetna Medicare Advantage and **Allina Health Aetna Medicare Members** send request to: **Phone:** 1-866-503-0857 **(TTY: 711)** **Fax:** 1-844-268-7263 **Availity:** https://www.aetna.com/health-care-professionals/resource-center/availity.html
For Aetna Medicare FIDE (HMO-DSNP) **Virginia Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Medicare FIDE (HMO-DSNP) **New Jersey Dual Eligible Special Needs Plans** send request to: **Phone:** 1-844-362-0934 **Fax:** 1-833-322-0034 **Availity:** https://www.aetnabetterhealth.com/new-jersey-hmosnp/providers/portal.html
For Aetna Medicare FIDE (HMO D-SNP) **Illinois Dual Eligible Special Needs Plans** send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Medicare HIDE (HMO D-SNP) **Michigan Dual Eligible Special Needs Plans** send request to: **Phone:** 1-855-676-5772 **Fax:** 1-844-241-2495 **Availity:** https://www.aetnabetterhealth.com/michigan/providers/portal.html

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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:
Provider Email:		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: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____
NPI: _____

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

E. PRODUCT INFORMATION

Request is for: Evenity® (romosozumab-aqqg): 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 is IV zoledronic acid followed by Jubbonti (denosumab-bbdz) or Prolia (denosumab) as secondary preferred products. Zoledronic acid does not require precertification.

☐ Yes ☐ No Has the patient received a dose of Evenity (romosozumab-aqqg) through insurance in the last 365 days? This does not include samples or doses administered without prior authorization.

☐ Yes ☐ No Has the patient had a documented inadequate response to both zoledronic acid and a secondary preferred product (either Jubbonti [denosumab-bbdz] or Prolia [denosumab])? Medical records (e.g., chart notes) documenting an inadequate response to a trial of zoledronic acid and a secondary preferred product must be available upon request
☐ Jubbonti (denosumab-bbdz) ☐ Prolia (denosumab) ☐ zoledronic acid

When was the member's inadequate response to the preferred drug(s)?

_____

Please describe the nature of the inadequate response of the preferred drug(s)

_____

☐ Yes ☐ No Has the patient had a documented intolerable adverse event to both zoledronic acid and a secondary preferred product (either Jubbonti [denosumab-bbdz] or Prolia [denosumab])? Medical records (e.g., chart notes) documenting an intolerable adverse event to a trial of zoledronic acid and a secondary preferred product must be available upon request
☐ Jubbonti (denosumab-bbdz) ☐ Prolia (denosumab ☐ zoledronic acid

When was the member's intolerable adverse event to the preferred drug(s)?

_____

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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.

For Initiation Requests (clinical documentation required for all requests):

Note: Evenity is non-preferred. The preferred product is IV zoledronic acid followed by Jubbonti (denosumab-bbdz) or Prolia (denosumab) as secondary preferred products.

Please describe the nature of the intolerable adverse event to the preferred drug(s)

_____

Please explain if there are any contraindications or any other 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)

☐ Jubbonti (denosumab-bbdz) ☐ Prolia (denosumab ☐ zoledronic acid

_____

What is the patient's creatinine clearance? _____ mL/min

Please provide the patient's Bone Mineral Density (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: _____

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: _____

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

Please indicate the number of monthly doses of Evenity the patient has received: _____

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.