



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

Page 1 of 2

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

Virginia (HMO D-SNP):
 FAX: 1-833-280-5224
 PHONE: 1-855-463-0933

For other lines of business:
 Please use other form.

Note: Evenity is non-preferred.
The preferred products for MA plans
are Prolia and IV zoledronic acid.
The preferred products for MAPD
plans are Forteo and Tymlos.

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 #: _____			Does patient have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Group #: _____			If yes, provide ID#: _____ Carrier Name: _____		
Insured: _____			Insured: _____		
C. PRESCRIBER INFORMATION					
First Name: _____			Last Name: _____ (Check One): <input type="checkbox"/> M.D. <input type="checkbox"/> D.O. <input type="checkbox"/> N.P. <input type="checkbox"/> 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:			Dispensing Provider/Pharmacy:		
<input type="checkbox"/> Self-administered <input type="checkbox"/> Physician's Office			<input type="checkbox"/> Physician's Office <input type="checkbox"/> Retail Pharmacy		
<input type="checkbox"/> Outpatient Infusion Center Phone: _____			<input type="checkbox"/> Specialty Pharmacy <input type="checkbox"/> Other _____		
Center Name: _____			Name: _____		
<input type="checkbox"/> Home Infusion Center Phone: _____			Address: _____		
Agency Name: _____			Phone: _____ Fax: _____		
<input type="checkbox"/> Administration code(s) (CPT): _____			TIN: _____ PIN: _____		
Address: _____					
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 products for MA plans are Prolia and IV zoledronic acid. The preferred products for MAPD plans are Forteo and Tymlos.					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had prior therapy with Evenity (romosozumab-aqqg) within the last 365 days?					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)					
<input type="checkbox"/> Prolia (denosumab) <input type="checkbox"/> IV zoledronic acid					
<input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had a trial, intolerance, or contraindication to any of the following? (select all that apply)					
<input type="checkbox"/> Forteo (teriparatide) <input type="checkbox"/> Tymlos (abaloparatide)					
<input type="checkbox"/> Yes <input type="checkbox"/> 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).					
<input type="checkbox"/> Prolia (denosumab) <input type="checkbox"/> 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 (select all that apply).					
<input type="checkbox"/> Forteo (teriparatide) <input type="checkbox"/> Tymlos (abaloparatide)					

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB
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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 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

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.