aetna®

MEDICARE FORM

Evenity® (romosozumab-aqqg) Injectable Medication Precertification Request

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

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

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 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:
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: _____
☐ Administration code(s) (CPT): _____
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): 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 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 (select all that apply).
☐ Forteo (teriparatide)

_____

Continued on next page

aetna®

MEDICARE FORM

Evenity® (romosozumab-aqqg) Injectable Medication Precertification Request

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

For Illinois MMP:
FAX: 1-855-320-8445
PHONE: 1-866-600-2139

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 product for MAPD plans is Forteo.

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 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.