



MEDICARE FORM

Evenity® (romosozumab-aqqg) Injectable Medication Precertification Request

Page 1 of 2

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

For Medicare Advantage Part B: Phone: 1-866-503-0857 (TTY: 711) FAX: 1-844-268-7263

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 teriparatide.

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

Precertification Requested By: Phone: Fax:

A. PATIENT INFORMATION

Form section A: Patient Information. Fields include First Name, Last Name, Address, City, State, ZIP, Home Phone, Work Phone, Cell Phone, DOB, Allergies, E-mail, Current Weight, Height.

B. INSURANCE INFORMATION

Form section B: Insurance Information. Fields include Aetna Member ID #, Group #, Insured, Does patient have other coverage?, Carrier Name.

C. PRESCRIBER INFORMATION

Form section C: Prescriber Information. Fields include First Name, Last Name, Address, City, State, ZIP, Phone, Fax, St Lic #, NPI #, DEA #, UPIN, Provider Email, Office Contact Name, Phone.

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Form section D: Dispensing Provider/Administration Information. Divided into Place of Administration and Dispensing Provider/Pharmacy.

E. PRODUCT INFORMATION

Form section E: Product Information. Field: Request is for: Evenity® (romosozumab-aqqg): Dose: Frequency: HCPCS Code:

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Form section F: Diagnosis Information. Fields: 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.

Form section G: Clinical Information. Includes initiation requests, medical history questions, and explanation fields.

Continued on next page



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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.

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? Does the patient have clinical evidence of uncorrected preexisting hypocalcemia? Is the patient at high risk for fractures? Has the patient had an osteoporotic fracture? 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.