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 are Prolia and IV zoledronic acid.

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 Advantage **Virginia Dual Eligible Special Needs Plans** (HMO D-SNP) send request to: **Phone:** 1-855-463-0933 **Fax:** 1-833-280-5224 **Availity:** https://www.aetnabetterhealth.com/virginia-hmosnp/providers/portal
For Aetna Assure Premier Plus Medicare Advantage **New Jersey Dual Eligible Special Needs Plans** (HMO D-SNP) 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 Better Health of **Illinois Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-866-600-2139 **FAX:** 1-855-320-8445 **Availity:** https://www.aetnabetterhealth.com/illinois/providers/portal
For Aetna Better Health of **Ohio Premier Medicare Medicaid Plan** (MMP) send request to: **Phone:** 1-855-364-0974 **Fax:** 1-855-734-9389 **Availity:** https://www.aetnabetterhealth.com/ohio/providers/portal
For Aetna Better Health of **Michigan Premier Medicare Medicaid Plan** (MMP) 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: ____________
☐ 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 are Prolia and IV zoledronic acid.

☐ Yes ☐ No Has the patient had prior therapy with Evenity (romosozumab-aqqg) within the last 365 days?
☐ No Has the patient had a trial and failure of BOTH of the following? (select all that apply)
- ☐ Prolia (denosumab) ☐ IV zoledronic acid
- → When was the member's trial and failure of the preferred drugs? ____________
- → Please describe the nature of the failure of the preferred drugs ____________

☐ No Has the patient had adverse reactions BOTH of the following? (select all that apply)
- ☐ Prolia (denosumab) ☐ IV zoledronic acid
- → When was the member's adverse reaction to the preferred drugs? ____________
- → Please describe the nature of the adverse reaction to the preferred drugs ____________

Please explain if there are any contraindications or other medical reason(s) that the patient cannot use BOTH of the following preferred products when indicated for the patient's diagnosis (select all that apply).
☐ Prolia (denosumab) ☐ IV zoledronic acid

____
____

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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?

☐ 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 How many monthly doses of Evenity has the patient received: ☐ 12 monthly doses or greater ☐ Less than 12 monthly doses

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.