Evenity

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Clinical Criteria Questions:

1. What is the indication?
   ❑ Postmenopausal osteoporosis
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Does the patient have a history of fragility fractures? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #11.*** ❑ Yes ❑ No
4. What is the patient's pre-treatment T-score? *Please provide the patient's T-score prior to initiation of osteoporosis treatment.* ***ACTION REQUIRED: Attach supporting chart note(s).***
   _____ ❑ Unknown *If less than or equal to -2.5 (ex. -3, -4), skip to #7.*
5. What is the patient's pre-treatment FRAX score for any major fracture? *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment (See Appendix).* ***ACTION REQUIRED: Attach supporting chart note(s).*** _____ % ❑ Unknown *If greater than or equal to 20% skip to #7.*
6. What is the patient's pre-treatment FRAX score for hip fracture? *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment (See Appendix).* ***ACTION REQUIRED: Attach supporting chart note(s).***
   _____ % ❑ Unknown
7. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo, Bonsity], denosumab [Prolia], abaloparatide [Tymlos])?
   If Yes, skip to #11 ❑ Yes ❑ No
8. Has the patient had at least a 1-year trial of an oral bisphosphonate? *If Yes, skip to #11* ❑ Yes ❑ No
9. Is there a clinical reason to avoid treatment with an oral bisphosphonate? ❑ Yes ❑ No
   If Yes, please indicate reason: _____
10. Does the patient have any indicators of very high fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores [-3 or below], increased fall risk)? ❑ Yes ❑ No
11. How many monthly doses of Evenity has the patient received? _____ doses

Appendix:

- *Calculator available at https://www.sheffield.ac.uk/FRAX/
- The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day.

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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