



Evenity

HMSACOM - 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 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. 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:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

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

Additional Demographic Information:

Patient Weight: _____ kg
Patient Height: _____ ft _____ inches

Indicate where the drug is being dispensed:

- Office Outpatient Hospital Ambulatory Surgical Inpatient Hospital
- Off Campus Outpatient Hospital Urgent Care Emergency Room Birthing Center
- Military Facility Skilled Nursing Facility Nursing Facility Hospice
- Inpatient Psychiatric Psychiatric Residential Treatment End Stage Renal Facility
- Psychiatric Facility Pharmacy Other

Indicate where the drug is being administered:

- Ambulatory surgical Home Inpatient Hospital
- Office Outpatient Hospital Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Evenity HMSACOM C24257-A – 01/2024.

CVS Caremark Specialty Programs • 2969 Mapunapuna Place • Honolulu, HI 96819
Phone: 1-808-254-4414 • Fax: 1-866-237-5512 • www.caremark.com

Criteria Questions:

1. What is the indication for Evenity?

Treatment of postmenopausal osteoporosis, *Continue to #100*

Other, *No Further Questions*

POSTMENOPAUSAL OSTEOPOROSIS

100. Does the member have a DEXA score of -3.0 or less? If yes, a copy of DEXA scan results must be submitted

Yes, *Continue to #300*

No, *Continue to #101*

101. Does the member have a history of greater than 2 vertebral fragility fractures? If yes, imaging studies supporting fracture must be submitted

Yes, *Continue to #300*

No, *Continue to #102*

102. Does the member have two moderate vertebral fragility fractures or reduction in vertebral body height of 26-40%? If yes, imaging studies supporting fracture or reduction in vertebral body height must be submitted

Yes, *Continue to #300*

No, *Continue to #103*

103. Does the member have one severe vertebral fragility fracture or reduction in vertebral body height of greater than 40%? If yes, imaging studies supporting fracture must be submitted

Yes, *Continue to #300*

No, *Continue to #104*

104. Is the member's pre-treatment bone mass T-score less than or equal to -2.5? If yes, a copy of DEXA scan results must be submitted

Yes, *Continue to #105*

No, *Continue to #108*

105. Does the member have a history of any vertebral or radial fracture? If yes, imaging studies supporting fracture must be submitted

Yes, *Continue to #106*

No, *Continue to #108*

106. Has the member experienced a documented inadequate response or intolerable adverse event to at least a 1-year trial of an oral or injectable bisphosphonate? If yes, supporting documentation must be submitted

Yes, *Continue to #300*

No, *Continue to #107*

107. Does the member have a clinical reason to avoid treatment with an oral or injectable bisphosphonate? If yes, supporting documentation must be submitted

Yes, *Continue to #300*

No, *Continue to #300*

108. Has the member experienced a documented inadequate response or intolerable adverse event to at least a 1-year trial of an oral or injectable bisphosphonate? If yes, supporting documentation must be submitted

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Yes, *Continue to #110*

No, *Continue to #109*

109. Does the member have a clinical reason to a void treatment with an oral or injectable bisphosphonate? If yes, supporting documentation must be submitted

Yes, *Continue to #110*

No, *Continue to #110*

110. Has the member failed prior treatment with or is unable to tolerate previous injectable osteoporosis therapy (e.g., Prolia, Tymlos) for which they are eligible? If yes, supporting documentation must be submitted

Yes, *Continue to #300*

No, *Continue to #300*

APPROVAL DURATION

300. How many months of treatment with Evenity has the member received in his/her lifetime?
_____ months of treatment, *No further Questions*

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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