Prolia and biosimilars

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? _____

Which product is being requested? ❒ Prolia ❒ Jubbonti ❒ Ospomyv ❒ Stoboclo

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

 Prolia and biosimilars HMSACOM – 06/2025.

Criteria Questions:

1. What is the diagnosis?

❒ Postmenopausal osteoporosis, *Continue to #2*

❒ Osteoporosis in a male patient, *Continue to #20*

❒ Glucocorticoid-induced osteoporosis, *Continue to #100*

❒ Breast Cancer, *Continue to #30*

❒ Prostate Cancer, *Continue to #31*

❒ Other, *No Further Questions*

Postmenopausal Osteoporosis

2. Does the patient have a history of fragility fractures? *If yes, please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *Continue to #3*

3. What is the patient's pretreatment T-score by dual-energy x-ray absorptiometry (DEXA) scan? *Please submit documentation with pre-treatment T score*. _____.

❒ ≤ -2.5, *Continue to #4*

❒ < -1 to > -2.5, *Continue to #8*

❒ Other/unknown, *No Further Questions*

4. What is the patient's pretreatment FRAX score for any major osteoporosis-related fracture? _____ %. *Please submit supporting documentation*

❒ > 20%, *No Further Questions*

❒ < 20%, *Continue to #5*

5. What is the patient's pretreatment FRAX score for hip fracture? _____ %. *Please submit supporting documentation*

❒ >3%, *No Further Questions*

❒ <3%, *Continue to #6*

6. Has the patient experienced an inadequate response or intolerable adverse event to at least a 1-year trial of an oral or injectable bisphosphonate? *If yes, please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *Continue to #7*

7. Does the patient have a clinical reason to avoid treatment with an oral or injectable bisphosphonate? *If yes, please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *Continue to #12*

8. What is the patient's pretreatment FRAX score for any major osteoporosis-related fracture? _____ %. *Please submit supporting documentation*

❒ > 20%, *Continue to #10*

❒ < 20%, *Continue to #9*

9. What is the patient's pretreatment FRAX score for hip fracture? _____%. *Please submit supporting documentation*

❒ >3%, *Continue to #10*

❒ <3%, *Continue to #12*

10. Has the patient experienced an inadequate response or intolerable adverse event to at least a 1-year trial of an oral or injectable bisphosphonate? *If yes, please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *Continue to #11*

11. Does the patient have a clinical reason to avoid treatment with an oral or injectable bisphosphonate? *If yes, please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *Continue to #12*

12. Has the patient experienced an inadequate response or intolerance to previous injectable osteoporosis therapy (e.g., Forteo, Bonsity, Tymlos, Evenity)? *If yes, please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *Continue to #13*

13. Has the patient exhausted the length of therapy allowed for injectable osteoporosis therapy (e.g., 12 months of Evenity, 24 months of Forteo)? *If yes, please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Osteoporosis in Men

20. Has the patient experienced an inadequate response or intolerable adverse event to at least a 1-year trial of an oral or injectable bisphosphonate? *If yes, please submit supporting documentation*

❒ Yes, *Continue to #22*

❒ No, *Continue to #21*

21. Does the patient have a clinical reason to avoid treatment with an oral or injectable bisphosphonate? *If yes, please submit supporting documentation*

❒ Yes, *Continue to #22*

❒ No, *Continue to #22*

22. Does the patient have a history of a vertebral or hip fracture? *If yes, please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *Continue to #23*

23. What is the patient's pretreatment T-score by dual-energy x-ray absorptiometry (DEXA) scan? *Please submit documentation with pre-treatment T score*. _____.

❒ ≤ -2.5, *No Further Questions*

❒ < -1 to > -2.5, *Continue to #24*

❒ Other/unknown, *Continue to #24*

24. What is the patient's pretreatment FRAX score for any major osteoporosis-related fracture? _____%. *Please submit supporting documentation*

❒ ≥ 20%, *No Further Questions*

❒ < 20%, *Continue to #25*

25. What is the patient's pretreatment FRAX score for hip fracture? _____%. *Please submit supporting documentation*

❒ ≥ 3%, *No Further Questions*

❒ < 3%, *No Further Questions*

Breast Cancer

30. Is the patient receiving adjuvant aromatase inhibition therapy for breast cancer? *Please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Prostate Cancer

31. Is the patient receiving androgen deprivation therapy for prostate cancer? *Please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

Glucocorticoid-Induced Osteoporosis

100. Is this a request for continuation of therapy with the requested drug?

❒ Yes, *Continue to #101*

❒ No, *Continue to #103*

101. What is the patient's current T-score? *Please submit documentation with pre-treatment T score*. _____.

❒ <3, *Continue to #102*

❒ >3, *Continue to #102*

102. Has the patient's T-score improved while taking the requested drug? *If yes, please submit supporting documentation*

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

103. Is the patient currently receiving glucocorticoid therapy or will the patient be initiating glucocorticoid therapy at a dose greater than or equal to 2.5 mg per day of prednisone or its equivalent for at least 3 months? *Documentation supporting the glucocorticoid dose and duration of therapy must be submitted*

❒ Yes, *Continue to #104*

❒ No, *Continue to #104*

104. Has the patient experienced an inadequate response or intolerable adverse event to at least a 1-year trial of an oral or injectable bisphosphonate? *If yes, please submit supporting documentation*

❒ Yes, *Continue to #106*

❒ No, *Continue to #105*

105. Does the patient have a clinical reason to avoid treatment with an oral or injectable bisphosphonate? *If yes, please submit supporting documentation*

❒ Yes, *Continue to #106*

❒ No, *Continue to #106*

106. Does the patient have a history of fragility fracture? If yes, please submit supporting documentation

❒ Yes, *No Further Questions*

❒ No, *Continue to #107*

107. What is the bone mass T score as measured by DEXA scan? *Please submit documentation with pre-treatment T score.* _____.

❒ T score less than or equal to −2.5, *No Further Questions*

❒ T score between −1.0 and −2.5, *Continue to #108*

❒ T score greater than or equal to −1.0, *Continue to #108*

108. What is the patient's pretreatment FRAX score for any major osteoporosis-related fracture? _____%. *Please submit supporting documentation*

❒ > 20%, *No Further Questions*

❒ < 20%, *Continue to #109*

109. What is the patient's pretreatment FRAX score for hip fracture? _____%. *Please submit supporting documentation*

❒ >3%, *No Further Questions*

❒ < 3%, *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)**