Evenity

CareFirst 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*

What is the ICD-10 code? _____

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

Criteria Questions:

1. What is the diagnosis?

❒ Postmenopausal osteoporosis, *Continue to 2*

❒ Other, please specify. _____, *Continue to 2*

2. Does the patient have a history of fragility fractures (e.g., low trauma fracture from force similar to a fall from standing position)? ***ACTION REQUIRED***: If Yes, attach supporting chart notes or medical record documentation.
❒ Yes, *Continue to 11*
❒ No, *Continue to 3*

3. 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) or medical record documentation.
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 4*

❒ Unknown, *Continue to 4*

4. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://frax.shef.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s) and medical record documentation.
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*
❒ Less than 20% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 5*

❒ Unknown, *Continue to 5*

5. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://frax.shef.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ***ACTION REQUIRED***: Attach supporting chart note(s) and medical record documentation.
❒ Greater than or equal to 3% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*
❒ Less than 3% _____ ***ACTION REQUIRED****: Submit supporting documentation, Continue to 6*

❒ Unknown, *Continue to 6*

6. 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], or increased fall risk)?

❒ Yes, *Continue to 11*
❒ No, *Continue to 7*

7. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo], a denosumab product [Prolia, Jubbonti, Ospomyv, Stoboclo], abaloparatide [Tymlos])?
❒ Yes, *Continue to 11*
❒ No, *Continue to 8*

8. Has the patient had at least a 1-year trial of an oral bisphosphonate?
❒ Yes, *Continue to 11*
❒ No, *Continue to 9*

9. Is there a clinical reason to avoid treatment with an oral bisphosphonate?
❒ Yes, *Continue to 10*
❒ No, *Continue to 10*

10. Please indicate the clinical reason to avoid treatment with an oral bisphosphonate.
❒ Presence of anatomic or functional esophageal abnormality that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility) _____, *Continue to 11*
❒ Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) _____, *Continue to 11*
❒ Presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders) _____, *Continue to 11*
❒ Inability to stand or sit upright for at least 30 to 60 minutes _____, *Continue to 11*
❒ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink, or medication of the day _____, *Continue to 11*
❒ Renal insufficiency (creatinine clearance less than 35 mL/min) _____, *Continue to 11*
❒ History of intolerance to an oral bisphosphonate _____, *Continue to 11*
❒ Other, please specify. _____, *Continue to 11*

11. How many monthly doses of Evenity has the patient received? Please indicate number of monthly doses the patient has received.
_____ monthly doses, *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)**

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

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com