Prolia and biosimilars

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? _____

What product is being requested? ❒ Prolia ❒ Bildyos ❒Bosaya ❒ Conexxence ❒ Enoby ❒ Jubbonti ❒ Ospomyv ❒ Stoboclo

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

Criteria Questions:

1. What is the diagnosis?

❒ Postmenopausal osteoporosis, *Continue to 2*

❒ Osteoporosis in a man, *Continue to 2*

❒ Glucocorticoid-induced osteoporosis, *Continue to 2*

❒ Breast cancer, *Continue to 2*

❒ Prostate cancer, *Continue to 2*

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

2. Is the request for continuation of therapy?
❒ Yes, *Continue to 3*
❒ No, *Continue to 8*

3. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?

❒ Yes, *Continue to 8*

❒ No, *Continue to 4*

❒ Unknown, *Continue to 8*

4. How long has the patient been receiving the requested drug?

❒ Less than 24 months, *Continue to 5*

❒ 24 months or more, *Continue to 6*

5. Has the patient experienced clinically significant adverse events during therapy?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

6. Has the patient experienced clinical benefit to therapy (i.e., improvement or stabilization in T-score since the previous bone mass measurement)?
❒ Yes, *Continue to 7*
❒ No, *Continue to 7*

7. Has the patient experienced any adverse effects?
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

8. What is the diagnosis?

❒ Postmenopausal osteoporosis, *Continue to 9*

❒ Osteoporosis in a man, *Continue to 18*

❒ Glucocorticoid-induced osteoporosis, *Continue to 25*

❒ Breast cancer, *Continue to 33*

❒ Prostate cancer, *Continue to 34*

9. 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 note(s) or medical record documentation.
❒ Yes, *No Further Questions*
❒ No, *Continue to 10*

10. 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 13*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 11*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****:* Submit supporting documentation*, No further questions*
❒ Unknown, *No further questions*

11. 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) or medical record documentation.
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****:* Submit supporting documentation, *Continue to 13*
❒ Less than 20% _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 12*
❒ Unknown, *Continue to 12*

12. 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) or medical record documentation.
❒ Greater than or equal to 3% _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 13*
❒ Less than 3% _____ ***ACTION REQUIRED****:* Submit supporting documentation, *Continue to 13*
❒ Unknown, *Continue to 13*

13. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], teriparatide [Forteo], abaloparatide [Tymlos])?
❒ Yes, *No Further Questions*
❒ No, *Continue to 14*

14. 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 Further Questions*
❒ No, *Continue to 15*

15. Has the patient had at least a 1-year trial of an oral bisphosphonate?
❒ Yes, *No Further Questions*
❒ No, *Continue to 16*

16. Is there a clinical reason to avoid treatment with an oral bisphosphonate?
❒ Yes, *Continue to 17*
❒ No, *Continue to 17*

17. Please indicate the clinical reason to avoid treatment with an oral bisphosphonate.
❒ Presence of anatomic or functional esophageal abnormalities that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility) _____, *No further questions*
❒ Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) _____, *No further questions*
❒ Presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders) _____, *No further questions*
❒ Inability to stand or sit upright for at least 30 to 60 minutes _____, *No further questions*
❒ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink, or medication of the day _____, *No further questions*
❒ Renal insufficiency (creatinine clearance less than 35 mL/min) _____, *No further questions*
❒ History of intolerance to an oral bisphosphonate _____, *No further questions*
❒ Other, please specify. _____, *No further questions*

18. Does the patient have a history of an osteoporotic vertebral or hip fracture? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record documentation.
❒ Yes, *No Further Questions*
❒ No, *Continue to 19*

19. 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 22*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 20*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****:* Submit supporting documentation*, No further questions*
❒ Unknown, *No further questions*

20. 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) or medical record documentation.
❒ Greater than or equal to 20% _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 22*
❒ Less than 20% _____ ***ACTION REQUIRED****:* Submit supporting documentation, *Continue to 21*
❒ Unknown, *Continue to 21*

21. 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) or medical record documentation.
❒ Greater than or equal to 3% _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 22*
❒ Less than 3% _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 22*
❒ Unknown, *Continue to 22*

22. Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate?
❒ Yes, *No Further Questions*
❒ No, *Continue to 23*

23. Is there a clinical reason to avoid treatment with a bisphosphonate?
❒ Yes, *Continue to 24*
❒ No, *Continue to 24*

24. Please indicate the clinical reason to avoid treatment with a bisphosphonate.
❒ Presence of anatomic or functional esophageal abnormalities that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility) _____, *No further questions*
❒ Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) _____, *No further questions*
❒ Presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders) _____, *No further questions*
❒ Inability to stand or sit upright for at least 30 to 60 minutes _____, *No further questions*
❒ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink, or medication of the day _____, *No further questions*
❒ Renal insufficiency (creatinine clearance less than 35 mL/min) _____, *No further questions*
❒ History of intolerance to an oral or injectable bisphosphonate _____, *No further questions*
❒ Other, please specify. _____, *No further questions*

25. Is the patient currently receiving or will be initiating glucocorticoid therapy at an equivalent prednisone dose of greater than or equal to 2.5 mg/day for 3 months or more?
❒ Yes, *Continue to 26*
❒ No, *Continue to 26*

26. Does the patient have a history of a fragility fracture (e.g., low trauma fracture from force similar to a fall from standing position)? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record documentation.
❒ Yes, *Continue to 30*
❒ No, *Continue to 27*

27. 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.

[PA Admin Instructions: (Please use fill-in-the blank format. Specify T-score.)]
❒ -2.5 or below (e.g., -2.6, -2.7, -3) _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 30*
❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) _____ ***ACTION REQUIRED****:* Submit supporting documentation, *Continue to 28*
❒ -1 or above (e.g., -0.9, -0.8, -0.5) _____ ***ACTION REQUIRED****:* Submit supporting documentation, *No further questions*

❒ Unknown, *No further questions*

28. 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 30*
❒ Less than 20% _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 29*

❒ Unknown, *Continue to 29*

29. 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) or medical record documentation.
❒ Greater than or equal to 3% _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 30*
❒ Less than 3% _____ ***ACTION REQUIRED****:* Submit supporting documentation*, Continue to 30*

❒ Unknown, *Continue to 30*

30. Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate?
❒ Yes, *No Further Questions*
❒ No, *Continue to 31*

31. Is there a clinical reason to avoid treatment with a bisphosphonate?
❒ Yes, *Continue to 32*
❒ No, *Continue to 32*

32. Please indicate the clinical reason to avoid treatment with a bisphosphonate.
❒ Presence of anatomic or functional esophageal abnormalities that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility) _____, *No further questions*
❒ Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) _____, *No further questions*
❒ Presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders) _____, *No further questions*
❒ Inability to stand or sit upright for at least 30 to 60 minutes _____, *No further questions*
❒ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink, or medication of the day _____, *No further questions*
❒ Renal insufficiency (creatinine clearance less than 35 mL/min) _____, *No further questions*
❒ History of intolerance to an oral or injectable bisphosphonate _____, *No further questions*
❒ Other, please specify. _____, *No further questions*

33. Will the requested drug be used for a patient receiving adjuvant aromatase inhibition therapy for breast cancer? ***ACTION REQUIRED***: If Yes, attach chart note(s), medical record documentation or claims history supporting the use of aromatase inhibition therapy.
❒ Yes, *No Further Questions*
❒ No, *No Further Questions*

34. Will the requested drug be used in a patient receiving androgen deprivation therapy for prostate cancer? ***ACTION REQUIRED***: If Yes, attach chart note(s), medical record documentation or claims history supporting the use of androgen deprivation therapy.
❒ Yes, *No Further Questions*
❒ No, *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