Reference number(s)
6447-D

This document applies to the following:

Formulary	Applies
Standard Control (SF)	☑
Standard Control – Choice (SCCF)	☑
Preferred Drug Plan Design (PDPD)	☐
Advanced Control Specialty (ACSF)	☑
Advanced Control Specialty – Choice (ACSCF)	☑
Managed Medicaid Template (MMT)	☐
Marketplace (MF)	☐
Aetna Small Group Affordable Care Act (SG ACA) Aetna Health Exchange (AHE)	☐
Aetna Individual Lives (IVL)	☐
Value (VF)	☑

Formulary	Applies
New to Market (NTM)	☐
Standard Formulary Chart (SFC)	☐
Basic Control Chart Preferred Drug Plan Design (BCC PDPD)	☐
Advanced Control Specialty Formulary Chart (ACSFC)	☐
Value Formulary Chart (VFC)	☐
Medical Benefit	☐
Medical Benefit: Advanced Biosimilars First	☐
Medical Benefit: Managed Medicaid (MMMB)	☐
Medicare Part B	☐
Medicare Part B: Advanced Biosimilars First	☐

Exceptions Criteria
Osteoporosis

This document informs prescribers of preferred products and provides an exception process for targeted products through prior authorization.

These criteria were developed to align with the following: Standard Control Formulary (SF), Standard Control Choice Formulary (SCCF), Advanced Control Specialty Formulary (ACSF), Advanced Control Specialty – Choice Formulary (ACSCF), and Value Formulary (VF).

Plan Design Summary

This program applies to the osteoporosis products specified in this document. Coverage for the targeted product is provided based on clinical circumstances that would exclude the use of the preferred products and may be based on previous use of a product. The coverage review process will ascertain situations where a clinical exception can be made. This program applies to members who are initiating a new treatment regimen with Evenity.

Each referral is reviewed based on all utilization management (UM) programs implemented for the client.

Table. Osteoporosis Products

Medications considered formulary or preferred on your plan may still require a clinical prior authorization review.

	Product(s)
Preferred	• Prolia (denosumab) • teriparatide (generic) • Tymlos (abaloparatide)
Target	• Evenity (romosozumab-aqqg)

Exception Criteria

This program applies to members requesting treatment for an indication that is FDA-approved for any of the preferred products.

Coverage for Evenity is provided when either of the following criteria is met:

- There is documentation that the member is currently undergoing treatment with the targeted product Evenity, and coverage is required to complete the current course of treatment.
- Member has a documented inadequate response, intolerable adverse event, or contraindication to all of the preferred products (e.g., cumulative treatment with Tymlos exceeding 24 months in a patient's lifetime).

References

1. Evenity [package insert]. Thousand Oaks, CA: Amgen, Inc.; April 2024.
2. Prolia [package insert]. Thousand Oaks, CA: Amgen Inc.; March 2024.
3. Teriparatide [package insert]. Weston, FL: Apotex Corp.; January 2023.
4. Tymlos [package insert]. Boston, MA: Radius Health, Inc.; December 2023.