Evenity

Prior Authorization Request

Your patient's benefit plan requires prior authorization for certain medications. In order to make appropriate medical necessity determinations, your patient's diagnosis and other clinical information is required. **Please complete the information requested on the form below and fax this form along with supporting clinical documentation to Priority Partners, toll-free at 1-866-212-4756 to initiate the review process.** If you have questions regarding the prior authorization please contact Priority Partners at 888-819-1043 Option 4.

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*

Drug Information:

Strength/Measure ______________________________*Units* ❑ ml ❑ Gm ❑ mg ❑ ea ❑ Un
Directions(sig) ________________________________*Route of administration* ________________________
Dosing frequency ______________________________

Site of Service Questions:

A. Indicate the site of service requested:
❑ *Ambulatory Surgical (POS Code 24)*
❑ *Off Campus Outpatient Hospital (POS Code 19)*
❑ *Office (POS Code 11)*
❑ *Home (POS Code 12)*
❑ *On Campus Outpatient Hospital (POS Code 22)*

B. Is the patient less than 18 years of age?
❑ Yes, *skip to Clinical Criteria Questions*
❑ No

C. Has the patient experienced an adverse event with the requested product that has not responded to conventional interventions (eg acetaminophen, steroids, diphenhydramine, fluids, other pre- medications or slowing of infusion rate) or a severe adverse event (anaphylaxis, anaphylactoid reactions, myocardial infarction, thromboembolism, or seizures) during or immediately after an infusion? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.*** ❑ Yes, *skip to Clinical Criteria Questions* ❑ No

D. Is the patient medically unstable which may include respiratory, cardiovascular, or renal conditions that may limit the member's ability to tolerate a large volume or load or predispose the member to a severe adverse event that cannot be managed in an alternate setting without appropriate medical personnel and equipment?

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ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

E. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

F. Does the patient have significant behavioral issues and/or physical or cognitive impairment that would impact the safety of the infusion therapy AND the patient does not have access to a caregiver? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

G. Has the patient's home been deemed not eligible or appropriate for home infusion services by a home infusion provider? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes, *skip to Clinical Criteria Questions* ❑ No

H. Does the patient have severe venous access issues that require the use of special interventions only available in the outpatient hospital setting? ***ACTION REQUIRED: If 'Yes', please attach supporting clinical documentation.***
❑ Yes ❑ No

Clinical Criteria Questions:

What is the ICD-10 code? _____________

1. What is the indication?

❒ Postmenopausal osteoporosis, *Continue to 2*

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

2. Does the patient have a history of fragility fractures? ***ACTION REQUIRED***: If Yes, attach supporting chart note(s) or medical record. ***ACTION REQUIRED***: Submit supporting 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.
❒ -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, No further questions*

❒ Unknown, *No further questions*

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://www.sheffield.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).
❒ 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*

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Priority Partners ● 7231 Parkway Drive Suite 100 ● Hanover, MD 21076
Phone: 888-819-1043 ● Fax: 1-866-212-4756 ● www.jhhc.com

❒ 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://www.sheffield.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).

❒ ______________________ %, ***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], 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, Bonsity], denosumab [Prolia], 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 reason.
____
____,
____*Continue to 11*

11. How many monthly doses of Evenity has the patient received?
______________________ 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 Priority Partners.

X____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Priority Partners Fax: 1-866-212-4756

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