Policy and Procedure	
PHARMACY PRIOR AUTHORIZATION AND STEP THERAPY POLICY AND CRITERIA ORPTCEND077.0425	**ENDOCRINE AND METABOLIC DRUGS** **OSTEOANABOLIC AGENTS** **Evenity®** (romosozumab-aqqg for subcutaneous injection)
Effective Date: 6/1/2025	**Review/Revised Date**: 03/23, 03/24, 02/25 (KN)
Original Effective Date: 06/22	**P&T Committee Meeting Date**: 04/22, 04/23, 04/24, 04/25
Approved by: Oregon Region Pharmacy and Therapeutics Committee	

SCOPE:
Providence Health Plan and Providence Health Assurance as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:
Medicare Part B

POLICY CRITERIA:

COVERED USES:
All Food and Drug Administration (FDA)-approved indications not otherwise excluded from the benefit

REQUIRED MEDICAL INFORMATION:
For osteoporosis, patient must meet ONE of the following criteria:

1. High risk of fracture defined as one of the following:
    a. Spine or hip bone mineral density (BMD) T-score of less than -3.0
    b. Very high fracture probability as indicated by a FRAX (Fracture Risk Assessment) score for hip fracture of greater than 4.5% or other major osteoporotic fracture of greater than 30%
    c. Fracture History:
        i. Fracture within the last 12 months
        ii. Fracture while on approved osteoporosis therapy
        iii. Multiple fractures
        iv. Fracture while on drugs causing skeletal harm (such as long-term glucocorticoids
    d. High risk of falls or history of injurious falls
2. Patient has one of the following:
    a. Trial and failure of anti-resorptive therapy (such as denosumab, bisphosphonates) defined as a new fracture or worsening BMD while adherent to therapy

b. Contraindication or intolerance to therapy with ALL the following: denosumab, oral bisphosphonate (such as alendronate), and IV bisphosphonate therapy (such as zoledronic acid)

EXCLUSION CRITERIA:
Concurrent use with another osteoanabolic agent (such as Evenity®, Forteo®, and Tymlos®)

Hypocalcemia

AGE RESTRICTIONS: N/A

PRESCRIBER RESTRICTIONS: N/A

COVERAGE DURATION:
May be approved for up to one year, ensuring the total duration of Evenity® therapy does not exceed one year of total therapy duration.

Requests for indications that were approved by the FDA within the previous six (6) months may not have been reviewed by the health plan for safety and effectiveness and inclusion on this policy document. These requests will be reviewed using the New Drug and or Indication Awaiting P&T Review; Prior Authorization Request ORPTCOPS047.

Requests for a non-FDA approved (off-label) indication requires the proposed indication be listed in either the American Hospital Formulary System (AHFS), Drugdex, or the National Comprehensive Cancer Network (NCCN) and is considered subject to evaluation of the prescriber's medical rationale, formulary alternatives, the available published evidence-based research and whether the proposed use is determined to be experimental/investigational.

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

INTRODUCTION:
Evenity® (romosozumab) is a monoclonal antibody (IgG2) that increases bone formation and, to a lesser extent, decreases bone resorption by binding to and inhibiting sclerostin. Evenity® is an anabolic osteoporosis medication with a unique mechanism of action compared to current anabolic agents on the market, abaloparatide (Tymlos®) and teriparatide (Forteo®). Evenity® is administered subcutaneously every month for a total therapy duration of 12 months and should be administered by a health care professional. The bone-building effect of Evenity® is gradually lost with continuous treatment; therefore, therapy is given for only 12 months. It is then necessary to follow that course of Evenity® with an anti-remodeling

agent such as a bisphosphonate or denosumab to maintain or improve the gains in bone mineral density and protection from fracture.

FDA APPROVED INDICATIONS:
Treatment of postmenopausal women with osteoporosis at high risk for fracture defined as a history of osteoporotic fracture, multiple risk factors for fracture, or patients who have failed or are intolerant to other available osteoporosis therapy.

POSITION STATEMENT:
The 2020 American Association of Clinical Endocrinologists/American College of Endocrinology (AACE/ACE) osteoporosis guidelines recommend that all postmenopausal women over the age of 50 be screened for osteoporosis risk. Treatment is recommended if the individual has osteoporosis or has osteopenia. First line agents that are recommended include alendronate, risedronate, zoledronic acid, and denosumab. The guidelines additionally recommend medications based on fracture risk. For individuals who have low to moderate risk of fracture, alendronate and risedronate are recommended. For individuals with highest risk of fracture and unable to use oral therapy, abaloparatide, denosumab, romosozumab, teriparatide, and zoledronic acid are recommended. The AACE/ACE guidelines further state that ibandronate or raloxifene may be appropriate initial therapy in some cases for patients requiring drugs with spine-specific efficacy. Raloxifene is not recommended for use in the ACP guidelines. Agents such as abaloparatide, romosozumab, and teriparatide may be preferred as initial therapy in patients with a very high risk of fracture. This includes patients with the following:

- Recent fracture (within previous 12 months)
- Fractures while on approved osteoporosis therapy
- Multiple fractures
- Fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids)
- High risk for falls or history of injurious falls
- Very high fracture probability as determined by the FRAX (fracture risk assessment tool) (e.g., major osteoporosis fracture > 30% or hip fracture > 4.5%) or another validated tool.

FRAX score assessment tool can be found at FRAX WHO Fracture Risk Assessment Tool website. http://www.sheffield.ac.uk/FRAX/tool.jsp?country=9

Contraindications to oral bisphosphonate therapy:

- Esophageal abnormalities (e.g., stricture or achalasia) that delay esophageal emptying
- Hypersensitivity to bisphosphonates

- Hypocalcemia; correct prior to initiation of therapy
- Inability to stand or sit upright for 60 minutes after administration of oral tablets

Contraindications to IV bisphosphonate therapy:

- Hypocalcemia
- Creatinine clearance less than 35 mL/min and in those with evidence of acute renal impairment due to an increased risk of renal failure
- Hypersensitivity to bisphosphonates

Evenity®

- There is moderate quality evidence that romosozumab may reduce vertebral fractures risks based on two phase 3, double-blind, multicenter, randomized clinical trials, FRAME and ARCH, that showed statistically significant fewer occurrences of new vertebral fractures at either 12 or 24 months in postmenopausal women ages 55 to 90 years.
- Per the prescribing information, Evenity should have a limit duration of use to 12 monthly doses. If osteoporosis therapy remains warranted, continued therapy with an anti-resorptive agent should be considered.
- Summary of Safety:
    - Boxed warning for major cardiac events (do not initiate in patients who have had a myocardial infarction or stroke within the preceding year)
    - Serious warnings and precautions include hypersensitivity reactions, hypocalcemia, osteonecrosis of the jaw, and atypical subtrochanteric and diaphyseal femoral fractures
    - No risk of osteosarcoma as seen in alternative anabolic agents include abaloparatide (Tymlos®) and teriparatide (Forteo®).

BILLING GUIDELINES AND CODING:

DRUG CODE*		
	J3111	Injection, romosozumab-aqqg, 1 mg
RELATED ADMINISTRATION CODES*		
	96372	Ther/proph/diag inj sc/im
	96401	Chemo anti-neopl sq/im

*Coding Notes:

• The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.

• HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as “medically unlikely edits” (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCE/RESOURCES:

1. Evenity® package insert. Thousand Oaks, CA: Amgen Inc; 2020 Apr.
2. Evenity® In: Lexi-Drugs Online [Internet database]. Hudson, OH: Lexi-Comp, Inc. Updated periodically. Accessed March 4, 2023.
3. American Association of Clinical Endocrinologists (AACE) and American College Of Endocrinology (ACE). AACE/ACE Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis — 2020 Update. Available at https://pro.aace.com/sites/default/files/2020-05/Vol%2026%20Supplement%201%20(May%202020)%20GL-2019-0524_0.pdf (Accessed March 4, 2024)
4. Managing Patients on Long-Term Bisphosphonate Treatment: American Society for Bone and Mineral Research, 2015.
5. Cosman F., Crittenden D.B, Adachi J.D., et al. “Romosozumab treatment in postmenopausal women with osteoporosis.” The New England Journal of Medicine. Vol. 375 (2016): 1532-1543.
6. Saag K.G, Peterson J., Brandi M.L., et al. “Romosozumab or alendronate for fracture prevention in women with osteoporosis. The New England Journal of Medicine. Vol. 377 (2017): 1417-1427.