Updated: 01/2021
DMMA Approved: 01/2021

Request for Prior Authorization for Evenity
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Evenity require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Evenity Prior Authorization Criteria:

Coverage may be provided with a diagnosis of osteoporosis in a postmenopausal woman and the following criteria is met:

- Documentation the member has one of the following
  - A documented T-score less than or equal to -2.5 in the lumbar spine, femoral neck, total hip, or 33% radius
  - History of a fragility fracture as an adult
  - A documented T-score is between -1.0 and -2.5 at the lumbar spine, total hip, femoral neck, or 33% radius AND one of the following:
    - Has a 10-year probability of a hip fracture is ≥ 3% or a 10-year probability of a major osteoporosis-related fracture ≥ 20% based on the US-adapted World Health Organization (WHO) algorithm (also known as FRAX)
    - History of osteoporotic fracture
- Documentation the member has tried and failed or had an intolerance or contraindication to the following:
    - oral bisphosphonate (i.e. alendronate)
    - Prolia (requires a prior authorization)
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - None – limited duration of use is 12 monthly doses. If osteoporosis therapy remains necessary continued therapy with an anti-resorptive agent should be considered.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

HIGHMARK. Delaware HEALTH OPTIONS

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EVENITY
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6251 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:

Did the member have a bone density test performed? ☐ Yes ☐ No
If yes, T-score result: _____
10-year probability score: _____
Do any of the following apply to the member (check all that apply):

- ☐ History of an osteoporotic fracture
- ☐ History of a fragility fracture
- ☐ The member is on an aromatase inhibitor
- ☐ The member is on androgen deprivation therapy

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date