HIGHMARK HEALTH OPTIONS

Updated: 07/2024
DMMA Approved: 07/2024

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

All requests for Injectable Osteoporosis Medications require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Injectable Osteoporosis Medications Prior Authorization Criteria:

For all requests for Injectable Osteoporosis Medications all of the following criteria must be met:

- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- For non-preferred agents, must have therapeutic failure, contraindication, or intolerance to one of the preferred Injectable Osteoporosis Medications approved of medically accepted for the member's diagnosis
- Documentation the member has tried (for at least 1 year) and failed an oral bisphosphonate therapy unless contraindicated, intolerant, experiencing an increased amount of fractures while on therapy, or the member is very high risk

Coverage will be provided with a diagnosis of low bone density or osteoporosis and the following criteria are met:

- The member is considered moderate or high risk for fracture determined by one of the following:
    - The member had a bone density test and the 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)
        - Is on an aromatase inhibitor
        - Is on androgen deprivation therapy
        - History of osteoporotic fracture
    - A documented T-score less than or equal to -2.5 in the lumbar spine, femoral neck, total hip, or 33% radius
    - History of fragility fracture as an adult
    - The member is on prednisone ≥7.5mg/day (or equivalent) and planning to continue therapy for at least 6 months and has one of the following:
        - A z score <-3 at hip or spine
        - A ≥10% per year bone loss of BMD at hip or spine
    - The member is on a glucocorticosteroid and has one of the following:
        - FRAX (glucocorticoid-adjusted) 10 year risk for major osteoporotic fracture ≥ 10%
        - FRAX (glucocorticoid-adjusted) 10 year risk for hip fracture > 1%

    - The member was recently on (within the past year) prednisone ≥30 mg/day and a cumulative dose of > 5 gm
- **Initial Duration of Approval:** 12 months
- **Reauthorization Criteria:**
    - **For Evenity (romosozumab-aqqg)**
        - None – limited duration of use is 12 monthly doses. If osteoporosis therapy remains necessary continued therapy with an anti-resorptive agent should be considered.
    - **All Other Medications**
        - Documentation of clinical improvement or stabilization of disease
- **Reauthorization Duration of approval:** 12 months

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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

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BONE RESORPTION AND RELATED AGENTS 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 8:00 am to 7:00 pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:	
Health Options ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
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

Diagnosis: ICD-10:

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

Is the member on prednisone ≥7.5mg/day (or equivalent) and planning to continue therapy for at least 6 months
☐ Yes ☐ No
If yes please provide one of the following:
Z score: _____
% bone loss per year _____

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FRAX (glucocorticoid-adjusted) 10 year risk for major osteoporotic fracture _____
FRAX (glucocorticoid-adjusted) 10 year risk for hip fracture _____
Was the member recently on (within the past year) prednisone ≥30 mg/day and a cumulative dose of > 5 gm?
☐ Yes ☐ No

Does the member have a documented history of therapeutic failure, intolerance, or contraindication to one of the preferred Bone Resorption Suppression and Related Agents indicated for the condition? ☐ Yes ☐ No
If **yes**, please document below in previous therapy section.

REAUTHORIZATION:

The member is stable or improving on therapy? ☐ Yes ☐ No
Please provide the following: Baseline T-score: _____ Date: _____

Please provide one of the following:
Current T-score: _____ Date: _____
☐ Not enough time has passed since the member's last T-score a repeat T-score will be done within 1 to 2 years since the previous T-score

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Physician Signature	Date