Please complete ALL information below and fax your request to 1-888-671-5285

Evenity™ Coverage Determination Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:	Office Contact:	
City:	State:	City:	State:		
Phone:			City:	Phone:	City:

Medication Information (required)

Medication Name: Select one of the following: ❑ Request is for **GENERIC** ❑ Request is for **BRAND** (unable to take the generic)	Strength:	Dosage Form:
❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the Type of Coverage Determination Requested:

❑ **Prior Authorization**- Request is for a drug that requires prior authorization under the plan.

Select the diagnosis below:

❑ Postmenopausal women with osteoporosis at high risk for fracture

❑ Other diagnosis: ____ ICD-10 Code(s): _______________________________________

Clinical Information:

Is the T-score of the patient's bone mineral density (BMD) at least -2.5 standard deviations below the young adult mean? ❑ **Yes** ❑ **No**

Does the patient have history of osteoporotic fracture (i.e., hip, spine, etc.)? ❑ **Yes** ❑ **No**

Select if the patient has had an inadequate response or inability to tolerate the following:

- ❑ Bisphosphonates
- ❑ Hormone replacement therapy
- ❑ Selective-estrogen receptor modulators (SERMs)

Has the patient had an inadequate response or inability to tolerate denosumab (Prolia)? ❑ **Yes** ❑ **No**

Is there documentation that patient's cumulative lifetime therapy does not exceed 12 months? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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