Nevada Medicaid

Submit fax request to: 855-455-3303
Please note: All information below is required to process this request.

Evenity® (romosozumab-aqqg)
Prior Authorization 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:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting brand ❑ Check if request is for initial trial ❑ Check if request is for recertification of therapy	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Diagnosis of postmenopausal osteoporosis or osteopenia

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Drug-Specific Information (required)

❑ The recipient's Bone Mineral Density (BMD) T-score is -2.5 or lower in the lumbar spine, femoral neck, total hip or radius (one-third radius site).

❑ The recipient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip or radius (one-third radius site).

❑ The recipient has documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm.

❑ The recipient has documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia® [denosumab]).

❑ The recipient has a FRAX 10-year probability of a major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions.

❑ The recipient has a FRAX 10-year probability of a hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions.

❑ The recipient has a documented trial and failure, contraindication or intolerance to Forteo® (teriparatide) or Tymlos® (abaloparatide).

❑ Treatment duration of Evenity® (romosozumab-aqqg) has not exceeded a total of 12 months during the recipient's lifetime.

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review.

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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