JOHNS HOPKINS MEDICINE / JOHNS HOPKINS HEALTHCARE	Johns Hopkins HealthCare LLC **Pharmacy Public** **Medical Management Drug Policies**	*Policy Number*	MMDP030
		Effective Date	07/17/2019
		Review Date	01/15/2020
	Subject **Evenity**	*Revision Date*	11/10/2021
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This document applies to the following Participating Organizations:

US Family Health Plan

Keywords: Evenity

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I. POLICY

Evenity (romosozumab-aqqg) will require prior authorization to ensure appropriate use. The process for initiating a prior authorization request can be found in policy PHARM 20.

II. POLICY CRITERIA

A. **Evenity** may be approved for patients who have the following condition and meet the following:
   I. Postmenopausal osteoporosis
      a. Patient is female and 18 years of age or older
      b. Documentation has been provided showing a diagnosis of postmenopausal osteoporosis
         1. AND **ONE** of the following:
            i. Bone Mineral Density (BMD) T-score of -2.5 or below in the lumbar spine, femoral neck, total, and/or 33% (one-third) radius OR
            ii. Patient is at high risk of fracture defined as:
               A. A history of previous osteoporotic (fragility) fracture (fracture of the spine, hip, proximal humerus, pelvis, or distal forearm) regardless of T-score OR
               B. Having a T-score between -1.0 and -2.5 in the spine, femoral neck, total hip, or 33% radius AND ONE of the following:
                  I. Fracture Risk Assessment (FRAX) 10-year probability for major osteoporotic fracture is 20% or greater, or the 10-year probability of hip fracture is 3% or greater OR
                  II. Documented history of repeat falls
      c. Documentation of treatment failure or contraindication to conventional osteoporosis therapy (two independent bisphosphonate regimens)

III. AUTHORIZATION PERIOD/LIMITATIONS

1. Initial authorization period will be limited to 12 months of therapy
2. Evenity will not be eligible for coverage renewal beyond the initial 12 months of treatment.

IV. EXCLUSIONS

1. Evenity will NOT be approved for patients with the following:
   a. Risk for osteosarcoma
   b. Paget's disease
   c. Unexplained elevations of alkaline phosphatase
   d. Prior bone radiation
   e. Bone metastases or a history of skeletal malignancies
   f. Metabolic bone diseases other than osteoporosis
   g. High levels of calcium
   h. Dual therapy with other human parathyroid hormone related peptide analogs, or monoclonal antibodies
2. Evenity is not recommended for more than 1 year of cumulative therapy, and will not be approved for continuation beyond this time.

V. RECOMMENDED DOSE

1. Evenity: 210 mg (two 105mg injections) subcutaneous injection delivered once monthly

VI. REFERENCES

1. Evenity: Prescribing information]. Thousand Oaks, CA: Amgen Inc; April 2019.
2. American Association of Clinical Endocrinologists and American College of Endocrinology. Clinical Practice 2016 Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis. Endocr. Pract. 2016 Sep;22(9):1111-8. Available at: https://journals.aace.com/doi/pdf/10.4158/EP161435.GL
3. WHO Fracture Risk Assessment Tool (FRAX). http://www.shef.ac.uk/FRAX (Accessed July, 2019)

VII. APPROVALS

Signature on file at JHHC

DATE OF REVISION	SUMMARY OF CHANGE
07/17/2019	Policy creation
01/15/2020	No policy changes- presented policy for USFHP adoption effective 3/1/2020
11/10/2021	Removed Priority Partners as an applicable LOB

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