MetroPlus Health

Policy and Procedure

Title: UM-PT132 Evenity (romosozumab)	**Division: Medical Management** **Department: Pharmacy**
Approval Date: 12/16/2025	**LOB: Medicaid, SNP, HARP, CHP, QHP, EP, Gold, Goldcare**
Effective Date: 12/16/2025	**Policy Number: UM-PT132**
Review Date: 12/16/2025	**Cross Reference Number:**
Retired Date:	**Page 1 of 4**

I. POLICY DESCRIPTION:

Sclerostin Inhibitor – Monoclonal Antibody – Evenity (romosozumab)

II. RESPONSIBLE PARTIES:

Medical Management Administration, Pharmacy Department, Utilization Management, Integrated Care Management, Claims Department

III. DEFINITIONS:

Evenity inhibits sclerostin, a regulatory factor in bone metabolism that inhibits Wnt/Beta-catenin signaling pathway. Evenity increases bone formation and, to a lesser extent, decreases bone resorption.

IV. POLICY:

Evenity will be considered medically necessary once the following coverage criteria is met. Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Chart notes must be submitted to confirm diagnosis and previous treatment(s).

INITIAL REQUEST:

1. Osteoporosis, postmenopausal, fracture risk reduction:

A. Documented diagnosis of postmenopausal osteoporosis;
AND
B. High risk of fracture defined by ONE of the following;
- **a.** History of osteoporotic fracture as an adult;
  OR
- **b.** Multiple risk factors for fracture (e.g. alcohol, smoking, low BMI, age, family history of osteoporosis, etc.);
  OR
- **c.** Failure or intolerance to other available osteoporosis therapy;

AND
C. Patient has ONE of the following:
- **a.** Bone mineral density (BMD) T-score of less than or equal to -2.5;
  OR
- b. 40 years of age and older AND has T-score between -1 and -2.5 with a Fracture Risk Algorithm (FRAX) 10-year risk of major osteoporotic fracture $\geq$ 20% or more OR FRAX 10-year risk of hip fracture $\geq$ 3%;

AND
D. Documentation of treatment failure, contraindication, or intolerance to at least ONE bisphosphonate therapy for at least 12 months;
AND

E. Documentation of treatment failure, contraindication, or intolerance to a RANKL-blocking agent (such as denosumab, etc..) for at least 12 months;

AND

F. Member is not to receive Evenity in combination with ANY of the following:

a. Parathyroid hormone analogs (e.g., Forteo, Tymlos);

OR

b. RANKL inhibitors (e.g., denosumab);

AND

G. Authorization is for a lifetime maximum of 12 months and may NOT be renewed

V. LIMITATIONS/ EXCLUSIONS:

Evenity will be considered experimental and investigational if prescribed for indications that have not been approved by the FDA and will not be covered under this policy.

VI. APPLICABLE PROCEDURE CODES:

CPT	Description
J3111	Injection, romosozumab-aqqg, 1mg

VII. APPLICABLE DIAGNOSIS CODES:

CODE	Description
M80.00XA – M80.08XS	Age-related osteoporosis with current pathological fracture
M81.0	Age-related osteoporosis with current pathological fracture
M81.8	Other osteoporosis without current pathological fracture

VIII. REFERENCES:

1. Evenity [package insert]. Thousand Oaks, CA: Amgen Inc.; December 2025.
2. Evenity. IBM Micromedex® DRUGDEX ® (electronic version). IBM Watson Health, Greenwood Village, Colorado, USA. Available at https://www.micromedexsolutions.com
3. IPD Analytics. New Drug Review.
4. IPD Analytics. ICD-10-CM CODES.

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REVISION LOG:

REVISIONS	INITIAL	DATE
Creation date	JL	12/16/2025

Approved:	**Date:**	**Approved:**	**Date:**
Suzana Patel	2/18/2026		02.18.2026
Suzana Patel, PharmD **Senior Director of Pharmacy**		**Sanjiv Shah, MD** **Chief Medical Officer**	

Medical Guideline Disclaimer:

 The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, Metroplus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information(including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered andor paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.

MetroPlus HealthPlan has adopted the herein policy in providing management, administrative and other services to our members, related to health benefit plans offered by our organization.