PRIOR AUTHORIZATION REQUEST
Tymlos

PATIENT: Name______________________
Address: ______________________
City, State, Zip_____________________
D.O.B. _____________________
Member ID:________________________

Prescriber: Name______________________
Address ______________________
City, State, Zip_____________________
Phone _____________________
Fax _____________________
NPI _____________________

Medication Requested:____________ Qty Requested: ____________

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. ☐ Yes ☐ No Is the patient currently receiving Tymlos or teriparatide or has the patient received Tymlos and/or teriparatide at any time in the past?
2. ☐ Yes ☐ No Has the patient received Tymlos and/or teriparatide for more than 2 years?
3. What is the indication or diagnosis?
   - ☐ Treatment of postmenopausal patients with osteoporosis – **Please answer questions 4 - 21**
   - ☐ Prevention of osteoporosis
   - ☐ All other indications or diagnoses – Please specify __ ____________________________________
4. ☐ Yes ☐ No Has the patient had a T-score (current or at any time in the past) at or below -2.5 at the lumbar spine, femoral neck, total hip and/or 33% (one-third) radius (wrist)?
5. ☐ Yes ☐ No Does the patient have low bone mass (T-score [current or at any time in the past] between -1.0 and -2.5 at the lumbar spine, femoral neck, total hip and/or 33% [one-third] radius [wrist])?
6. ☐ Yes ☐ No Does the prescriber determine the patient is at high risk for fracture?
7. ☐ Yes ☐ No Has the patient had an osteoporotic fracture or fragility fracture?
8. ☐ Yes ☐ No Has the patient tried Ibandronate sodium 3 MG/3 ML OR Zoledronic acid 5 MG/100ML?
9. ☐ Yes ☐ No Has the patient tried ibandronate injection (Boniva) or zoledronic acid injection (Reclast)?
10. ☐ Yes ☐ No Has the patient tried at least one oral bisphosphonate or oral bisphosphonate-containing product?
11. ☐ Yes ☐ No Has the patient had an inadequate response to oral bisphosphonate therapy after a trial duration of 12 months as determined by the prescriber (for example, ongoing and significant loss of bone mineral density [BMD], lack of BMD increase)?
12. ☐ Yes ☐ No Has the patient had an osteoporotic fracture or fragility fracture while receiving oral bisphosphonate therapy?

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13. ☐ Yes ☐ No Has the patient experienced intolerability to an oral bisphosphonate (for example: severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture)?
14. ☐ Yes ☐ No Is the patient unable to take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing?
15. ☐ Yes ☐ No Is the patient unable to take an oral bisphosphonate because the patient cannot remain in an upright position post oral bisphosphonate administration?
16. ☐ Yes ☐ No Is the patient unable to take an oral bisphosphonate because the patient has a pre-existing GI medical condition (for example: patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia])?
17. ☐ Yes ☐ No Has the patient had an osteoporotic fracture or a fragility fracture?
18. ☐ Yes ☐ No Does the patient have severe renal impairment (for example: creatinine clearance < 35 mL/min)?
19. ☐ Yes ☐ No Does the patient have chronic kidney disease?
20. ☐ Yes ☐ No Will Tymlos be used in combination with other medications for osteoporosis?
21. How many months of therapy with Tymlos and/or teriparatide has the patient received in his/her lifetime?

☐ 0 months
☐ 1 month
☐ 2 months
☐ 3 months
☐ 4 months
☐ 5 months
☐ 6 months
☐ 7 months
☐ 8 months
☐ 9 months
☐ 10 months
☐ 11 months
☐ 12 months
☐ 13 months
☐ 14 months
☐ 15 months
☐ 16 months
☐ 17 months
☐ 18 months
☐ 19 months
☐ 20 months

If you have any questions, call: 800-753-2851

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- ☐ 21 months
- ☐ 22 months
- ☐ 23 months
- ☐ 24 months

Please document the diagnoses, symptoms, and/or any other information important to this review:

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SECTION B Physician Signature

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PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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