PRIOR AUTHORIZATION REQUEST

Forteo

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 Is the patient currently receiving Tymlos or teriparatide or has the patient received Tymlos and/or teriparatide at any time in the past?
[If no, skip to question 3.]

2 Has the patient received Tymlos and/or teriparatide for more than 2 years?
[If yes, no further questions.]

3 What is the diagnosis or indication?
[] Treatment of postmenopausal patients with osteoporosis (If checked, go to 4)

[] Treatment of glucocorticoid-induced osteoporosis (If checked, go to 20)

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PRIOR AUTHORIZATION REQUEST

[] Osteoporosis in men (to increase bone mass in men) with primary or hypogonadal osteoporosis
[Reviewer Note: If the request is by phone, please read the definition of a man to the caller if the indication or diagnosis is osteoporosis in men. Men are defined as individuals with the biological traits of a man, regardless of the individual's gender identity or gender expression.] (If checked, go to 21)

[] Hypoparathyroidism (If checked, go to 37)

[] Prevention of osteoporosis (If checked, no further questions)

[] Other (If checked, no further questions)

4 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 percent (one-third) radius (wrist)?
[If yes, skip to question 8.]

5 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 percent [one-third] radius [wrist])?
[If no, skip to question 7.]

6 Did the prescriber determine that the patient is at high risk for fracture?
[If yes, skip to question 8.]

7 Has the patient had an osteoporotic fracture or fragility fracture?
[If no, no further questions.]

8 Has the patient tried ibandronate sodium 3 mg/3 ml OR zoledronic acid 5 mg/100 ml?
[If yes, skip to question 39.]

9 Has the patient tried ibandronate injection (Boniva) or zoledronic acid injection (Reclast)?
[If yes, skip to question 39.]

10 Has the patient tried at least one oral bisphosphonate or oral bisphosphonate-containing product?
[Note: Examples of oral bisphosphonates or oral bisphosphonate-containing products include alendronate (Fosamax), Fosamax-D, Actonel, Atelvia, and ibandronate (Boniva).]
[If no, skip to question 14.]

11 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)?
[If yes, skip to question 39.]

12 Has the patient had an osteoporotic fracture or fragility fracture while receiving oral bisphosphonate therapy?
[Note: Examples of oral bisphosphonates or oral bisphosphonate-containing products include alendronate (Fosamax), Fosamax-D, Actonel, Atelvia, and ibandronate (Boniva).]
[If yes, skip to question 39.]

13 Has the patient experienced intolerability to an oral bisphosphonate (for example, severe GI-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture)?

PRIOR AUTHORIZATION REQUEST

[Note: Examples of oral bisphosphonates or oral bisphosphonate- containing products include alendronate (Fosamax), Fosamax-D, Actonel, Atelvia, and ibandronate (Boniva).]
[If yes, skip to question 39.]

14 Is the patient unable to take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing?
[If yes, skip to question 39.]

15 Is the patient unable to take an oral bisphosphonate because the patient cannot remain in an upright position post oral bisphosphonate administration?
[If yes, skip to question 39.]

16 Is the patient unable to take an oral bisphosphonate because the patient has a pre-existing gastrointestinal medical condition (for example, patients with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia])?
[If yes, skip to question 39.]

17 Has the patient had an osteoporotic fracture or a fragility fracture?
[If yes, skip to question 39.]

18 Does the patient have severe renal impairment (for example, creatinine clearance less than 35 mL/min)?
[If yes, skip to question 39.]

19 Does the patient have chronic kidney disease?
[If yes, skip to question 39.]
[If no, no further questions.]

20 Is the patient either initiating or continuing systemic glucocorticoids (for example, prednisone)?
[If yes, skip to question 25.]
[If no, no further questions.]

21 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 percent (one-third) radius (wrist)?
[If yes, skip to question 25.]

22 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 percent [one-third] radius [wrist])?
[If no, skip to question 24.]

23 Did the prescriber determine that the patient is high risk for fracture?
[If yes, skip to question 25.]

24 Has the patient had an osteoporotic fracture or fragility fracture?
[If no, no further questions.]

25 Has the patient tried zoledronic acid 5 mg/100 ml?
[If yes, skip to question 39.]

PRIOR AUTHORIZATION REQUEST

26 Has the patient tried zoledronic acid injection (Reclast)?
[If yes, skip to question 39.]

27 Has the patient tried at least one oral bisphosphonate or oral bisphosphonate-containing product?
[Note: Examples of oral bisphosphonates or oral bisphosphonate-containing products include alendronate (Fosamax), Fosamax-D, Actonel, Atelvia, and ibandronate (Boniva).]
[If no, skip to question 31.]

28 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)?
[If yes, skip to question 39.]

29 Has the patient had an osteoporotic fracture or fragility fracture while receiving oral bisphosphonate therapy?
[Note: Examples of oral bisphosphonates or oral bisphosphonate-containing products include alendronate (Fosamax), Fosamax-D, Actonel, Atelvia, and ibandronate (Boniva).]
[If yes, skip to question 39.]

30 Has the patient experienced intolerability to an oral bisphosphonate (for example, severe gastrointestinal-related adverse effects, severe musculoskeletal-related side effects, a femoral fracture)?
[Note: Examples of oral bisphosphonates or oral bisphosphonate- containing products include alendronate (Fosamax), Fosamax-D, Actonel, Atelvia, and ibandronate (Boniva).]
[If yes, skip to question 39.]

31 Is the patient unable to take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing?
[If yes, skip to question 39.]

32 Is the patient unable to take an oral bisphosphonate because the patient cannot remain in an upright position post oral bisphosphonate administration?
[If yes, skip to question 39.]

33 Is the patient unable to take an oral bisphosphonate because the patient has a pre-existing gastrointestinal medical condition (for example, patients with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia])?
[If yes, skip to question 39.]

34 Has the patient had an osteoporotic fracture or a fragility fracture?
[If yes, skip to question 39.]

35 Does the patient have severe renal impairment (for example, creatinine clearance less than 35 mL/min)?
[If yes, skip to question 39.]

PRIOR AUTHORIZATION REQUEST

36 Does the patient have chronic kidney disease?
[If yes, skip to question 39.]
[If no, no further questions.]

37 Is the requested medication being prescribed by or in consultation with an endocrinologist?
[If no, no further questions.]

38 Has the patient tried Natpara (parathyroid hormone injection), or is Natpara not available?
[No further questions.]

39 Will the requested medication be used in combination with other medications for osteoporosis?
[Note: Examples include Prolia (denosumab for SC injection), oral bisphosphonates (for example, alendronate, risedronate, ibandronate), intravenous bisphosphonates (zoledronic acid injection [Reclast], intravenous ibandronate), calcitonin nasal spray (Miacalcin/Fortical), Tymlos (abaloparatide injection for SC use), and Evenity (romosozumab-aqqg injection for subcutaneous).]
[If yes, no further questions.]

40 How many months of therapy with teriparatide and/or Tymlos has the patient received in his/her lifetime?
[] 0 months (If checked, no further questions)

[] 1 month (If checked, no further questions)

[] 2 months (If checked, no further questions)

[] 3 months (If checked, no further questions)

[] 4 months (If checked, no further questions)

[] 5 months (If checked, no further questions)

[] 6 months (If checked, no further questions)

[] 7 months (If checked, no further questions)

[] 8 months (If checked, no further questions)

[] 9 months (If checked, no further questions)

[] 10 months (If checked, no further questions)

[] 11 months (If checked, no further questions)

[] 12 months (If checked, no further questions)

[] 13 months (If checked, no further questions)

[] 14 months (If checked, no further questions)

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PRIOR AUTHORIZATION REQUEST

[] 15 months (If checked, no further questions)

[] 16 months (If checked, no further questions)

[] 17 months (If checked, no further questions)

[] 18 months (If checked, no further questions)

[] 19 months (If checked, no further questions)

[] 20 months (If checked, no further questions)

[] 21 months (If checked, no further questions)

[] 22 months (If checked, no further questions)

[] 23 months (If checked, no further questions)

[] 24 months (If checked, no further questions)

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

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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