maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Tymlos

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.

CRITERIA FOR APPROVAL

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.]	Yes	No
2	Has the patient received Tymlos and/or teriparatide for more than 2 years? [If yes, no further questions.]	Yes	No
3	What is the diagnosis or indication? [] Treatment of postmenopausal patients with osteoporosis (If checked, go to 4)		

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	[] 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% (one-third) radius (wrist)? [If yes, skip to question 8.]	Yes	No
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.]	Yes	No
6	Did the prescriber determine that the patient is at high risk for fracture? [If yes, skip to question 8.]	Yes	No
7	Has the patient had an osteoporotic fracture or fragility fracture? [If no, no further questions.]	Yes	No
8	Has the patient tried ibandronate sodium 3 mg/3 ml OR zoledronic acid 5 mg/100 ml? [If yes, skip to question 20.]	Yes	No
9	Has the patient tried ibandronate injection (Boniva) or zoledronic acid injection (Reclast)? [If yes, skip to question 20.]	Yes	No
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.]	Yes	No
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 20.]	Yes	No
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 20.]	Yes	No
13	Has the patient experienced intolerability to an oral bisphosphonate (for example,	Yes	No

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	severe GI-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 20.]		
14	Is the patient unable to take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing? [If yes, skip to question 20.]	Yes	No
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 20.]	Yes	No
16	Is the patient unable to take an oral bisphosphonate because the patient has a pre-existing gastrointestinal medical condition (for example, patient with esophageal lesions, esophageal ulcers, or abnormalities of the esophagus that delay esophageal emptying [stricture, achalasia])? [If yes, skip to question 20.]	Yes	No
17	Has the patient had an osteoporotic fracture or a fragility fracture? [If yes, skip to question 20.]	Yes	No
18	Does the patient have severe renal impairment (for example, creatinine clearance less than 35 mL/min)? [If yes, skip to question 20.]	Yes	No
19	Does the patient have chronic kidney disease? [If no, no further questions.]	Yes	No
20	Will Tymlos be used in combination with other medications for osteoporosis? [Note: Examples include Prolia (denosumab injection for subcutaneous use), oral bisphosphonates (alendronate, risedronate, ibandronate), intravenous bisphosphonates (zoledronic acid injection [Reclast], ibandronate intravenous), calcitonin nasal spray (Miacalcin/Fortical), teriparatide injection for subcutaneous use (Forteo/Bonsity), and Evenity (romosozumab-aqqg injection for subcutaneous use).] [If yes, no further questions.]	Yes	No
21	How many months of therapy with Tymlos and/or teriparatide 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)		

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[] 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)

[] 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:

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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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