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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1 Is this request for initial therapy or for a continuation of therapy?

[] Initial (If checked, go to 9)

[] Continuation (If checked, go to 2)

2 Is the patient currently receiving the requested medication? Yes No
[If no, skip to question 9.]

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3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 9.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 9.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 9.]	Yes	No
6	Has the patient received Tymlos and/or teriparatide for more than 2 years? [If yes, no further questions.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	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)

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

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

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

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[] 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)

9 What is the diagnosis or indication?

[] Treatment of postmenopausal patients with osteoporosis (If checked, go to 10)

[] Treatment to increase bone density in men with osteoporosis at high risk for fracture (If checked, go to 27)

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

[] Other (If checked, no further questions)

10	Has the patient had an osteoporotic fracture or fragility fracture? [If yes, skip to question 14.]	Yes	No
11	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 14.]	Yes	No
12	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, no further questions.]	Yes	No
13	Did the prescriber determine that the patient is at high risk for fracture? [If no, no further questions.]	Yes	No

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14	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 18.]	Yes	No
15	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 24.]	Yes	No
16	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 24.]	Yes	No
17	Has the patient experienced intolerability to an oral bisphosphonate (for example, 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 24.]	Yes	No
18	Is the patient unable to take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing? [If yes, skip to question 24.]	Yes	No
19	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 24.]	Yes	No
20	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 24.]	Yes	No
21	Has the patient had an osteoporotic fracture or a fragility fracture? [If yes, skip to question 24.]	Yes	No
22	Does the patient have severe renal impairment (for example, creatinine clearance less than 35 mL/min)? [If yes, skip to question 24.]	Yes	No

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23	Does the patient have chronic kidney disease? [If no, no further questions.]	Yes	No
24	Has the patient tried and failed ibandronate injection (Boniva) or zoledronic acid injection (Reclast), or have an intolerance or contraindication to ibandronate injection (Boniva) or zoledronic acid injection (Reclast)? [If no, no further questions.]	Yes	No
25	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

26 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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[] 24 months (If checked, no further questions)

27	Does the patient have a history of an osteoporotic vertebral or hip fracture greater than 12 months from the time of request? ACTION REQUIRED: Please submit supporting documentation. [If yes, skip to question 30.]	Yes	No
28	Has the patient had a pretreatment T-score (current or at any time in the past) at or below -2.5 at the lumbar spine, femoral neck, or total hip? ACTION REQUIRED: Please submit supporting documentation. [If yes, skip to question 30.]	Yes	No
29	Does the patient have a pretreatment T-score at or above between -1.0 and -2.5 at the lumbar spine, femoral neck, or total hip and at a high risk of fracture? ACTION REQUIRED: Please submit supporting documentation. [If no, no further questions.]	Yes	No
30	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 34.]	Yes	No
31	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.]	Yes	No

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32	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.]	Yes	No
33	Has the patient experienced intolerability to an oral bisphosphonate (for example, 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 39.]	Yes	No
34	Is the patient unable to take an oral bisphosphonate because the patient cannot swallow or has difficulty swallowing? [If yes, skip to question 39.]	Yes	No
35	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.]	Yes	No
36	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 39.]	Yes	No
37	Does the patient have severe renal impairment (for example, creatinine clearance less than 35 mL/min)? [If yes, skip to question 39.]	Yes	No
38	Does the patient have chronic kidney disease? [If no, no further questions.]	Yes	No
39	Has the patient tried and failed zoledronic acid 5 mg/100 mL? [If yes, skip to question 41.]	Yes	No
40	Has the patient experienced intolerability to or has a contraindication to use of zoledronic acid 5 mg/100 mL? [If no, no further questions.]	Yes	No
41	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	Yes	No

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use (Forteo/Bonsity), and Evenity (romosozumab-aqqg injection for subcutaneous use).]
[If yes, no further questions.]

42 How many months of therapy with Tymlos and/or teriparatide has the patient received in his/her lifetime?

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[] 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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