pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

BONE RESORPTION SUPPRESSION AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Bone Resorption Suppression Agents** and **Quantity Limits/Daily Dose Limits** are accessible on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/State/Zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Actonel tablet
☐alendronate oral solution
☐Atelvia DR tablet
☐Binosto effervescent tablet
☐Boniva monthly tablet
☐calcitonin-salmon nasal spray
☐etidronate tablet
☐Fosamax tablet
☐Fosamax Plus D weekly tablet
☐risedronate DR weekly tablet
☐ _____

For Evista/raloxifene requests, please use the "Evista (raloxifene) Form." For Forteo or Tymlos, use the "Forteo & Tymlos Form". For all other injectable agents, please use the "Injectable Bone Resorption Suppression Agents Form."

Strength:	Directions:	Quantity:	Refills:

Diagnosis *(submit documentation)*:	Dx code (*required*):
1. Does the Beneficiary have results of a recent bone mineral density test (BMD)?	☐Yes – *Submit documentation of BMD test results.* ☐No
2. Do any of the following apply to the Beneficiary? *Check all that apply.* ☐history of low-trauma spine or hip fracture or other fragility fracture ☐10-year probability of hip fracture ≥ 3% based on the US-adapted WHO algorithm ☐10-year probability of major fracture related to osteoporosis ≥ 20% based on the US-adapted WHO algorithm	☐Yes ☐No *Submit all supporting documentation risk score.*
3. Was the Beneficiary evaluated for other possible causes of osteoporosis, including the following laboratory tests? *Check all that apply.* ☐CBC ☐albumin ☐intact parathyroid hormone (PTH) ☐Vitamin D ☐total protein ☐creatinine ☐ionized calcium ☐thyroid stimulating hormone (TSH) ☐liver enzymes/LFTs ☐phosphorous ☐urinary calcium excretion ☐testosterone (if male)	☐Yes ☐No *Submit results of all requested lab results.*
4. Does the Beneficiary have a history of trial and failure, contraindication, or intolerance to the following preferred oral agents? *Check all that apply.* ☐alendronate tablet (5mg, 10mg, 35mg, 40mg, or 70mg) ☐ibandronate monthly tablet ☐risedronate tablet (5mg, 30mg, 35mg, or 150mg)	☐Yes ☐No *Submit all supporting documentation of trial and failure, intolerance, or contraindications.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: