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 DENSITY REGULATORS – EVENITY / FORTEO / TERIPARATIDE / TYMLOS

PRIOR AUTHORIZATION FORM *(form effective 1/3/2022)*

Prior authorization guidelines for **Bone Density Regulators** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

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

CLINICAL INFORMATION

Drug requested:	☐Evenity injection ☐Forteo injection	☐teriparatide injection ☐Tymlos injection	☐other: _____
Directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Dx code (*required*):	

INITIAL requests

What is the beneficiary's T-score? T-score: _____ Date of test: _____ *Submit documentation and results of BMD testing.*

Do any of the following apply to the beneficiary? *Check all that apply.* ☐Has a history of fragility fracture ☐Has a history of multiple vertebral fractures	☐Yes ☐No	*Submit all supporting documentation.*
Was the beneficiary evaluated for other possible causes of osteoporosis, including the following laboratory tests? *Check all that apply.* ☐CBC ☐albumin ☐thyroid stimulating hormone (TSH) ☐vitamin D ☐total protein ☐urinary calcium excretion ☐ionized calcium ☐creatinine ☐intact parathyroid hormone (PTH) ☐phosphorous ☐liver enzymes/LFTs ☐testosterone (if male)	☐Yes ☐No	*Submit results of all requested lab tests.*
Requests for Forteo/teriparatide or Tymlos: Does the beneficiary have a history of any of the following? *Check all that apply.* ☐Paget's disease ☐metabolic bone disorder other than osteoporosis ☐bone metastases ☐prior external beam or implant radiation therapy involving the skeleton ☐skeletal malignancy ☐unexplained elevations in alkaline phosphatase ☐open epiphyses ☐hypercalcemic disorders	☐Yes ☐No	*Submit all supporting documentation.*
Requests for Evenity: Does the beneficiary have a history of either of the following: *Check all that apply.* ☐myocardial infarction ☐stroke	☐Yes ☐No	*Submit all supporting documentation.*
Does the beneficiary have a history of trial and failure of (i.e., documented continued bone loss or a fragility fracture after 2 or more years of treatment) or contraindication or intolerance to bisphosphonates (e.g., alendronate, risedronate, zoledronic acid, etc.)?	☐Yes ☐No.	*Submit documentation of trial and failure, intolerance, or contraindications*

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Has the beneficiary been using or previously used an anabolic Bone Density Regulator (Forteo/teriparatide, Tymlos [abaloparatide], Evenity [romosozumab])?	☐ Yes – *Submit documentation of start and end dates.* ☐ No
Requests for Evenity or Tymlos: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to **teriparatide**?	☐ Yes – *Submit documentation.* ☐ No
Requests for Forteo: Does the beneficiary have a contraindication or intolerance to **teriparatide** that would not be expected to occur with Forteo?	☐ Yes – *Submit documentation.* ☐ No
RENEWAL requests	
Since the requested medication was last approved, did the beneficiary have a follow-up bone mineral density (BMD) test performed?	☐ Yes – *Submit documentation of BMD test results.* ☐ No

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

Prescriber Signature:	Date: