

FORTEO (teriparatide) & TYMLOS (abaloparatide) PRIOR AUTHORIZATION FORM

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>.

<input type="checkbox"/> New request	<input type="checkbox"/> 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

Medication requested:	<input type="checkbox"/> Forteo injection	<input type="checkbox"/> Tymlos injection
Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):	

INITIAL requests

Does the beneficiary have results of a recent bone mineral density test (BMD)?	<input type="checkbox"/> Yes – <i>Submit documentation of BMD test results.</i> <input type="checkbox"/> No
Do any of the following apply to the beneficiary? <i>Check all that apply.</i> <input type="checkbox"/> history of low-trauma spine or hip fracture or other fragility fracture <input type="checkbox"/> 10-year probability of hip fracture \geq 3% based on the US-adapted WHO algorithm <input type="checkbox"/> 10-yr prob. of major fracture related to osteoporosis \geq 20% based on the US-adapted WHO algorithm	<input type="checkbox"/> Yes <i>Submit all supporting documentation.</i> <input type="checkbox"/> No
Was the beneficiary evaluated for other possible causes of osteoporosis, including the following laboratory tests? <i>Check all that apply.</i> <input type="checkbox"/> CBC <input type="checkbox"/> vitamin D <input type="checkbox"/> ionized calcium <input type="checkbox"/> phosphorous <input type="checkbox"/> albumin <input type="checkbox"/> total protein <input type="checkbox"/> creatinine <input type="checkbox"/> liver enzymes/LFTs <input type="checkbox"/> thyroid stimulating hormone (TSH) <input type="checkbox"/> urinary calcium excretion <input type="checkbox"/> intact parathyroid hormone (PTH) <input type="checkbox"/> testosterone (if male)	<input type="checkbox"/> Yes <i>Submit results of all requested lab tests.</i> <input type="checkbox"/> No
Does the beneficiary have a history of any of the following? <i>Check all that apply.</i> <input type="checkbox"/> Paget's disease <input type="checkbox"/> bone metastases <input type="checkbox"/> skeletal malignancy <input type="checkbox"/> open epiphyses <input type="checkbox"/> metabolic bone disorder other than osteoporosis <input type="checkbox"/> prior external beam or implant radiation therapy involving the skeleton <input type="checkbox"/> unexplained elevations in alkaline phosphatase <input type="checkbox"/> hypercalcemic disorders	<input type="checkbox"/> Yes <i>Submit all supporting documentation.</i> <input type="checkbox"/> No
Does the beneficiary have a history of trial and failure of (ie, documented continued bone loss or a fragility fracture after 2 or more years of treatment) or contraindication or intolerance to bisphosphonates (eg, alendronate, risedronate, zoledronic acid, etc)?	<input type="checkbox"/> Yes <i>Submit documentation of trial and failure, intolerance, or contraindications</i> <input type="checkbox"/> No.
Has the beneficiary been using or previously used Forteo or Tymlos?	<input type="checkbox"/> Yes – <i>Submit documentation of start and end dates.</i> <input type="checkbox"/> No
Requests for Tymlos: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to Forteo ?	<input type="checkbox"/> Yes – <i>Submit documentation.</i> <input type="checkbox"/> No

RENEWAL requests

Since the requested medication was last approved, did the beneficiary have a follow-up bone mineral density (BMD) test performed?	<input type="checkbox"/> Yes – <i>Submit documentation of BMD test results.</i> <input type="checkbox"/> No
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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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