PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Tymlos® (abaloparatide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☒ Tymlos prefilled pen 80 mcg/dose

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must either:

1. For osteoporosis at high risk of fracture in postmenopausal women with **no history** of an osteoporotic fracture, the patient:
   - must have a documented treatment failure, contraindication* or ineffective response** to a minimum (12) month trial on previous therapy with an oral bisphosphonate such as alendronate, risendronate or ibandronate; and
   - must have a documented treatment failure, contraindication* or ineffective response** to a minimum (12) month trial on previous therapy with one of the following zoledronic acid (generic Reclast) *or* Prolia.***

—or—

2. For osteoporosis at high risk of fracture in postmenopausal women patients **who have a history** of an osteoporotic fracture, the patient:
   - must have a documented treatment failure, contraindication*, or ineffective response** to a minimum (12) month trial on previous therapy with one of the following: alendronate, ibandronate, risedronate, zoledronic acid (generic Reclast), or Prolia***

*Examples of contraindications to oral bisphosphonate therapy include the following:
- Documented inability to sit or stand upright for at least 30 minutes
- Documented pre-existing gastrointestinal disorder such as inability to swallow, esophageal stricture, or achalasia

**Ineffective response is defined as one of the following:
- Decrease in T-score in comparison with baseline T-score from DEXA scan
- Patient has a new fracture while on bisphosphonate therapy

***Prolia requires prior authorization.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 07/2017

Last reviewed 01/2019

Additional information

Note: Tymlos may be authorized for up to two years in a lifetime. Additional efficacy beyond two years has not been established.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Postmenopausal osteoporosis
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Has the patient had one or more osteoporotic fractures?

- ☐ Yes Date(s): _____
- ☐ No

C. Which of the following medications has the patient had a therapeutic trial with?

- ☐ alendronate (generic for Fosamax)
- ☐ ibandronate (generic for Boniva)
- ☐ risedronate (generic for Actonel)

D. Which of the following injectable medications has the patient had a therapeutic trial with?

- ☐ zoledronic acid (generic Reclast)
- ☐ Prolia

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