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 80 mcg pen injector

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 meet the following:

1. For the treatment of osteoporosis in postmenopausal women, must have a T-score less than or equal to -3 with a previous low-impact fracture, and meet **all** of the following:
   - Documented failure of an oral bisphosphonate (or documented intolerance or contraindication) despite compliance for at least 2 years (Note: Failure of any trials (including drugs below) is defined by new fracture while on treatment or reduction in bone mineral density (BMD) per recent DEXA scan).
   - Documented failure or intolerance to a compliant (at least 12 month) regimen of zoledronic acid (generic Reclast).

Additional information

Note: Parathyroid hormone analogs will be authorized for up to a total of two years in a lifetime. Additional efficacy beyond two years has not been established. Also, if member has a new fracture while on a bisphosphonate, a clinical trial is only required of one bisphosphonate (oral or IV).

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.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2018

Last reviewed 07/2020

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Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Osteoporosis in postmenopausal women
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

B. Has the patient had a low-impact fracture?

☐ Yes Date(s): _____
☐ No

C. What is the patient's baseline DEXA T-score? _____ Date: _____

D. What are the patient's DEXA T-score's on treatment?

T-score: _____ Date: _____
T-score: _____ Date: _____

E. Please list previous osteoporosis medications trialed, including dates of use, and outcome:

Medication: _____ Dates used: _____ Outcome: _____

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