

SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If information provided is not complete, correct, or legible, authorization may be delayed.

Parathyroid Hormone Analogs

Drug Requested: Select one drug below

<input type="checkbox"/> Forteo® (teriparatide) injection	<input type="checkbox"/> generic teriparatide (Forteo®)	<input type="checkbox"/> Tymlos® (abaloparatide) injection
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MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Weight (if applicable): _____ Date weight obtained: _____

Quantity Limit: Maximum 2.24 mL/28 days for teriparatide (Forteo®). Maximum 1.56 mL/28 days for Tymlos. Maximum 24-month approval (total cumulative lifetime therapy) for **ALL** parathyroid analog products

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

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SECTION A: Diagnosis Criteria (All applicable criteria MUST be met for approval)

- Member must have **ONE** of the following diagnoses:
 - Female with post-menopausal osteoporosis
 - Male with primary or hypogonadal osteoporosis
 - Systematic glucocorticoid-induced osteoporosis
- Diagnosis of osteoporosis was confirmed by **ONE** of the following (**chart notes, radiographs, BMD assessment or FRAX assessment must be submitted for documentation**):
 - Member has a history of vertebral fracture(s), low trauma or fragility fracture(s) [e.g., prior fracture from minor trauma such as falling from standing height or less] within the past 5 years
 - Member has a T-score that is ≤ -2.5 in spine, femoral neck, total hip or 1/3 radius OR T-score is -1 to >-2.5 with high pre-treatment FRAX fracture probability (10-year major osteoporotic fracture risk $\geq 20\%$ or hip fracture risk $\geq 3\%$)
 - Member has a very high risk for fracture* defined as a T-score ≤ -3.0 , a T-score ≤ -2.5 with a history of fragility fractures [e.g., prior fracture from minor trauma such as falling from standing height or less] or severe or multiple vertebral fractures

***Provider Please Note:** Members with very high risk for fracture as documented above are **NOT** subject to prior trial and failure requirements with bisphosphonates.

SECTION B: Prerequisite Therapy Criteria (All applicable criteria MUST be met for approval)

- Member must meet **ONE** of the following prior trial and failure requirements:
 - Member has had a 12-month minimum trial of **ONE (1)** of the following bisphosphonates with evidence of no bone mineral density (BMD) improvement at end of trials, decline in BMD, or fracture while on bisphosphonate therapy (**submit BMD assessments, radiographs and/or chart note documentation of failures**):

□ alendronate (Fosamax®)	□ ibandronate (Boniva®)
□ risedronate (Actonel®)	□ zoledronic acid (Reclast®)
 - Member has a documented intolerance, FDA-labeled contraindication, or hypersensitivity to both an oral and IV bisphosphonate defined by two of the following (documentation of contraindication or hypersensitivity must be submitted):

□ Hypersensitivity to TWO bisphosphonates (one of which must be alendronate)
□ Inability to stand or sit upright for at least 30 minutes
□ Pre-existing gastrointestinal disorders (e.g., Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, atrophic gastritis)
□ Uncorrected hypocalcemia
□ Severe renal insufficiency as defined by CrCL < 35 mL/min for alendronate agents and zoledronic acid or CrCL < 30 mL/min for risedronate and ibandronate

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- ❑ For approval of Brand Forteo® or Tymlos®, member must have had trial and failure of generic teriparatide injection (**chart notes documenting therapy failure must be submitted for documentation**)

SECTION C: Contraindications (**All criteria MUST be met for approval**)

- ❑ Member is NOT currently using and will NOT initiate therapy with a bisphosphonate, SERM, calcitonin (Miacalcin or Fortical), denosumab (Prolia or Xgeva), or Evenity (romosozumab) while using the requested medication
- ❑ Member does NOT have any contraindication to therapy with the requested agent, including history of skeletal irradiation, history of osteosarcoma, open epiphyses, Paget's disease, hypercalcemia or hyperparathyroidism

Medication being provided by Specialty Pharmacy – Proprium Rx

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****