

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**):

<input type="checkbox"/> alendronate (Fosamax [®])	<input type="checkbox"/> ibandronate (Boniva [®])
<input type="checkbox"/> risedronate (Actonel [®])	<input type="checkbox"/> 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):

<input type="checkbox"/> Hypersensitivity to <u>TWO</u> bisphosphonates (one of which must be alendronate)
<input type="checkbox"/> Inability to stand or sit upright for at least 30 minutes
<input type="checkbox"/> Pre-existing gastrointestinal disorders (e.g., Barrett's esophagus, hypersecretory disorders, delayed esophageal emptying, atrophic gastritis)
<input type="checkbox"/> Uncorrected hypocalcemia
<input type="checkbox"/> 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.****