SENTARA COMMUNITY PLAN
(MEDICAID)

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 the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Select one drug below

Non-Preferred	
❑ **Forteo®** (teriparatide)	❑ **Tymlos™** (abaloparatide)
❑ **Bonsity®** (teriparatide)	❑ **teriparatide** (recombinant) injection

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 Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

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

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.

Initial Authorization Approval: 1 year

1. Is member 18 years or older? ❑ Yes ❑ No
2. Does the member have a confirmed diagnosis of osteoporosis? ❑ Yes ❑ No

(Continued on next page)

3. Has the member experienced a therapeutic failure or inadequate response to at least two bisphosphonates? ❑ Yes ❑ No
   If **YES**, list drugs tried and failed:
   If **NO**, is patient unable to receive or have a contraindication to a bisphosphonate?
   List details: _____
4. Will the member be taking calcium and vitamin D supplementation if dietary intake is inadequate? ❑ Yes ❑ No
5. Is member a postmenopausal woman with a diagnosis of osteoporosis? **OR** ❑ Yes ❑ No
6. Is the member assigned male at birth requiring increased bone mass with primary or hypogonadal osteoporosis **OR** ❑ Yes ❑ No
7. Does the member have osteoporosis associated with sustained glucocorticoid therapy (for example more than 6 months use of greater than 7.5mg per day of prednisone or an equivalent)? ❑ Yes ❑ No
8. Does the member have a history of osteoporotic fracture? **OR** ❑ Yes ❑ No
9. Is the member at a high risk for fractures? ❑ Yes ❑ No
10. Does member have a documented Hip DXA (femoral neck or total hip) or lumbar spine T-score -2.5 (standard deviations) or below? **OR** ❑ Yes ❑ No
11. Does member have Bone Mineral Density (BMD) of -3 or worse? ❑ Yes ❑ No
12. Patient has **NOT** received therapy with Tymlos in excess of 24 months in total? **(Please note: safety and efficacy had NOT been evaluated beyond 2 years of treatment.)** ❑ Yes ❑ No

*****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.****

REVISED/UPDATED/REFORMATTED: ~~6/30/2017; 8/29/2017; 8/20/2018; 4/2/2019; 4/18/2019; 6/29/2021; 3/31/2023; 11/7/2023; 6/6/2024, 9/10/2025;~~ **6/26/2026**