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 patient 18 years or older? ❑ Yes ❑ No
2. Does patient have a confirmed diagnosis of osteoporosis? ❑ Yes ❑ No

(Continued on next page)

3. Has patient 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. Is patient assigned male at birth requiring increased bone mass with primary or hypogonadal osteoporosis?
   ❑ Yes ❑ No
5. Is patient at a high risk for fractures? ❑ Yes ❑ No
6. Will patient be taking calcium and vitamin D supplementation if dietary intake is inadequate?
   ❑ Yes ❑ No
7. Does patient have a documented Hip DXA (femoral neck or total hip) or lumbar spine T-score -2.5 (standard deviations) or below? ❑ Yes ❑ No
8. Does patient have Bone Mineral Density (BMD) of -3 or worse? ❑ Yes ❑ No
9. Is patient a postmenopausal woman with history of non-traumatic fracture(s)? ❑ Yes ❑ No
10. Is patient a postmenopausal woman with two or more of the following clinical risk factors?

(Check boxes below that apply)

❑ Family history of non-traumatic fracture(s)	❑ History of non-traumatic fracture(s)
❑ DXA BMD T-score ≤ -2.5 at any site	❑ Rheumatoid Arthritis
❑ More than 2 alcohol beverages per day	❑ Current smoker
❑ Glucocorticoid use (≥ 6 months of use at 7.5 dose of prednisolone equivalent)	

11. Patient has **NOT** received therapy with Tymlos in excess of 24 months in total? **(Please note: safety and efficacy has 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.

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