# Tymlos (abaloparatide)
# Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

**Instructions:** Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

| **MEMBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PHONE NUMBER:** | **DATE OF BIRTH:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **PATIENT INSURANCE ID NUMBER:** | |

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

**IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP**

**PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE):** _____
**AUTHORIZED REPRESENTATIVE'S PHONE NUMBER:** _____

| **PRESCRIBER INFORMATION** | |
|---|---|
| **LAST NAME:** | **FIRST NAME:** |
| **PRESCRIBER SPECIALTY:** | **EMAIL ADDRESS:** |
| **NPI NUMBER:** | **DEA NUMBER:** |
| **PHONE NUMBER:** | **FAX NUMBER:** |
| **STREET ADDRESS:** | |
| **CITY:** | **STATE:** **ZIP CODE:** |
| **REQUESTOR** (if different than prescriber)**:** | **OFFICE CONTACT PERSON:** |

| **MEDICATION OR MEDICAL DISPENSING INFORMATION** | | | |
|---|---|---|---|
| **MEDICATION NAME:** | | | |
| **DOSE/STRENGTH:** | **FREQUENCY:** | **LENGTH OF THERAPY/REFILLS:** | **QUANTITY:** |
| ☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES): | | **IF RENEWAL:** DATE THERAPY INITIATED: | |

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**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

| **1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?** ☐ YES (if yes, complete below) ☐ NO | | |
|---|---|---|
| **MEDICATION/THERAPY** (SPECIFY DRUG NAME AND DOSAGE)**:** | **DURATION OF THERAPY** (SPECIFY DATES)**:** | **RESPONSE/REASON FOR FAILURE/ALLERGY:** |
| | | |

| **2. LIST DIAGNOSES:** | **ICD-10:** |
|---|---|
| ☐ Hypogonadal osteoporosis<br>☐ Idiopathic osteoporosis<br>☐ Osteoporosis associated with systemic glucocorticoid therapy<br>☐ Postmenopausal osteoporosis<br>☐ Severe osteoporosis<br>☐ Other diagnosis: _____ICD-10_____ | |

**3. REQUIRED CLINICAL INFORMATION:** PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

**Has the patient had prior treatment with Forteo (teriparatide)? ☐ Yes ☐ No**

**Has the patient ever been treated with a bisphosphonate? ☐ Yes ☐ No Please provide documentation.**

**Does the patient have reflux/GERD OR severe renal disease, as defined by a CrCl less than 35 mL/min? * ☐ Yes ☐ No**

**Please provide documentation.**

**Has the patient failed previous treatment with at least one bisphosphonate (i.e., Fosamax [alendronate], Actonel [risedronate], Boniva [ibandronate], or Reclast [zoledronic acid])? ☐ Yes ☐ No Please provide documentation.**

**Has the patient been intolerant to previous treatment with at least one bisphosphonate (i.e., Fosamax [alendronate], Actonel [risedronate], Boniva [ibandronate], or Reclast [zoledronic acid])? * ☐ Yes ☐ No Please provide documentation.**

**Was the treatment failure measured by a decline in bone mineral density in g/cm2 of greater than or equal to 3% in the spine and/or hip while on bisphosphonate therapy? * ☐ Yes ☐ No Please provide documentation.**

**Was the treatment failure due to a fracture while being treated with bisphosphonate therapy and did this fracture occur in the past 3 years?* ☐ Yes ☐ No**

**Does patient have a diagnosis of severe osteoporosis with very high fracture risk? ☐ Yes ☐ No Please provide documentation.**

**Does patient have a very low T-score (eg, T-score of ≤-3.0) even in the absence of fracture(s)? ☐ Yes ☐ No Please provide documentation.**

**Does patient have a T-score of ≤-2.5 plus a fragility fracture? ☐ Yes ☐ No Please provide documentation.**

**Does patient have severe or multiple vertebral fractures? ☐ Yes ☐ No Please provide documentation.**

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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**MEMBER'S LAST NAME:** _____ **MEMBER'S FIRST NAME:** _____

**Please note:** Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

**ATTESTATION:** I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

**Prescriber Signature or Electronic I.D. Verification:** _____ **Date:** _____



**FAX THIS FORM TO: 800-424-7640**
**MAIL REQUESTS TO:** Prime Therapeutics Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811