

**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](http://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:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

*Continued on next page.*

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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

<b>MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):</b>	<b>DURATION OF THERAPY (SPECIFY DATES):</b>	<b>RESPONSE/REASON FOR FAILURE/ALLERGY:</b>

**2. LIST DIAGNOSES:** **ICD-10:**

<input type="checkbox"/> Hypogonadal osteoporosis <input type="checkbox"/> Idiopathic osteoporosis <input type="checkbox"/> Osteoporosis associated with systemic glucocorticoid therapy <input type="checkbox"/> Postmenopausal osteoporosis <input type="checkbox"/> Other diagnosis: _____ ICD-10 _____	
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**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

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

**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

**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

**Was the treatment failure measured by a decline in bone mineral density in g/cm<sup>2</sup> of greater than or equal to 3% in the spine and/or hip while on bisphosphonate therapy? \***  Yes  No

**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

*\*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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**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:** \_\_\_\_\_



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**MEMBER'S LAST NAME:** \_\_\_\_\_ **MEMBER'S FIRST NAME:** \_\_\_\_\_

**CONFIDENTIALITY NOTICE:** The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

**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