PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

Patient Name: _____ **Date:** 5/13/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
Physician Office Address: _____
_
Drug Name (specify drug) _____
Quantity: _____ **Frequency:** _____ **Strength:** _____
Route of Administration: _____ **Expected Length of Therapy:** _____
Diagnosis: _____ **ICD Code:** _____
Comments: _____
_____
_____

Please check the appropriate answer for each applicable question.

1. What is the diagnosis?
   - Postmenopausal osteoporosis (If checked, go to 2) ☐
   - Osteoporosis in a man (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
   _____

2. How many months of cumulative parathyroid hormone analog therapy (teriparatide and abaloparatide) has the patient received in their lifetime?
   - Less than 24 months (If checked, go to 3) ☐
   - _____ 24 months or more (If checked, no further questions) ☐
   _____

3. Is the request for continuation of therapy? **Y** ☐ **N** ☐

4. Is the patient currently receiving Tymlos through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 7) ☐
   - No (If checked, go to 5) ☐
   - Unknown (If checked, go to 7) ☐

5. Has the patient experienced clinically significant adverse events during therapy? **Y** ☐ **N** ☐

6. How many months of cumulative parathyroid hormone analog therapy (teriparatide and abaloparatide) has the patient received in their lifetime?
   - Less than 12 months (If checked, no further questions) ☐
   - 12 months (If checked, no further questions) ☐

13 months (If checked, no further questions) ☐

14 months (If checked, no further questions) ☐

15 months (If checked, no further questions) ☐

16 months (If checked, no further questions) ☐

17 months (If checked, no further questions) ☐

18 months (If checked, no further questions) ☐

19 months (If checked, no further questions) ☐

20 months (If checked, no further questions) ☐

21 months (If checked, no further questions) ☐

22 months (If checked, no further questions) ☐

23 months (If checked, no further questions) ☐ 24 months or longer (If checked, no further questions) ☐

7. What is the diagnosis?

Postmenopausal osteoporosis (If checked, go to 8) ☐

Osteoporosis in a man (If checked, go to 17) ☐

8. Does the patient have a history of fragility fractures? ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical record. **Y** ☐ **N** ☐
ACTION REQUIRED: Submit supporting documentation

9. What is the patient's pre-treatment T-score? Indicate the patient's T-score prior to initiation of osteoporosis treatment. ACTION REQUIRED: Attach supporting chart note(s) or medical record.

-2.5 or below (e.g., -2.6, -2.7, -3) (If checked, go to 12) ☐

_____

Between -2.5 and -1 (e.g., -2.4, -2.3, -2) (If checked, go to 10) ☐

_____

-1 or above (e.g., -0.9, -0.8, -0.5) (If checked, no further questions) ☐

_____ Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

10. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ACTION REQUIRED: Attach supporting chart note(s).

Greater than or equal to 20% (If checked, go to 12) ☐

_____ Less than 20% (If checked, go to 11) ☐

_____

Unknown (If checked, go to 11) ☐

ACTION REQUIRED: Submit supporting documentation

11. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment.

NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ACTION REQUIRED: Attach supporting chart note(s).

Greater than or equal to 3% (If checked, go to 12) ☐

Less than 3% (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

12. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], denosumab [Prolia], teriparatide [Forteo, Bonsity])? **Y** ☐ **N** ☐

13. Does the patient have any indicators of very high fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores [-3 or below], increased fall risk)? **Y** ☐ **N** ☐

14. Has the patient had at least a 1-year trial of an oral bisphosphonate? **Y** ☐ **N** ☐

15. Is there a clinical reason to avoid treatment with an oral bisphosphonate? **Y** ☐ **N** ☐

16. Please indicate the clinical reason to avoid treatment with an oral bisphosphonate.

Presence of anatomic or functional esophageal abnormality that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility) (If checked, go to 24) ☐

Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) (If checked, go to 24) ☐

Presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders) (If checked, go to 24) ☐

Inability to stand or sit upright for 30 to 60 minutes (If checked, go to 24) ☐

Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink, or medication of the day (If checked, go to 24) ☐

Renal insufficiency (creatinine clearance less than 35 mL/min) (If checked, go to 24) ☐

History of intolerance to an oral bisphosphonate (If checked, go to 24) ☐

Other, please specify. (If checked, no further questions) ☐

17. Does the patient have a history of an osteoporotic vertebral or hip fracture? ACTION REQUIRED: If yes, attach supporting chart note(s) or medical record. ACTION REQUIRED: Submit supporting documentation **Y** ☐ **N** ☐

18. What is the patient's pre-treatment T-score? Indicate the patient's T-score prior to initiation of osteoporosis treatment. ACTION REQUIRED: Attach supporting chart note(s) or medical record.

-2.5 or below (e.g., -2.6, -2.7, -3) (If checked, go to 21) ☐

Between -2.5 and -1 (e.g., -2.4, -2.3, -2) (If checked, go to 19) ☐

-1 or above (e.g., -0.9, -0.8, -0.5) (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

19. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for any major fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ACTION REQUIRED: Attach supporting chart note(s).

Greater than or equal to 20% (If checked, go to 21) ☐

Less than 20% (If checked, go to 20) ☐

Unknown (If checked, go to 20) ☐

ACTION REQUIRED: Submit supporting documentation

20. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score for hip fracture? Please provide the patient's FRAX score prior to initiation of osteoporosis treatment. NOTE: Calculator available at https://www.sheffield.ac.uk/FRAX/. The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine [clinical], hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day. ACTION REQUIRED: Attach supporting chart note(s).

Greater than or equal to 3% (If checked, go to 21) ☐

Less than 3% (If checked, no further questions) ☐

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

21. Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate? **Y** ☐ **N** ☐

22. Is there a clinical reason to avoid treatment with a bisphosphonate? **Y** ☐ **N** ☐

23. Please indicate the clinical reason to avoid treatment with a bisphosphonate.

Presence of anatomic or functional esophageal abnormalities that might delay transit of the tablet (e.g., achalasia, stricture, or dysmotility) (If checked, go to 24) ☐

Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) (If checked, go to 24) ☐

Presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders) (If checked, go to 24) ☐

Inability to stand or sit upright for 30 to 60 minutes (If checked, go to 24) ☐

Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink, or medication of the day (If checked, go to 24) ☐

Renal insufficiency (creatinine clearance less than 35 mL/min) (If checked, go to 24) ☐

History of intolerance to an oral or injectable bisphosphonate (If checked, go to 24) ☐

Other, please specify. (If checked, no further questions) ☐

24. How many months of cumulative parathyroid hormone analogs therapy (teriparatide and abaloparatide) has the patient received in their lifetime?

- Less than 12 months (If checked, no further questions) ☐
- 12 months (If checked, no further questions) ☐
- 13 months (If checked, no further questions) ☐
- 14 months (If checked, no further questions) ☐
- 15 months (If checked, no further questions) ☐
- 16 months (If checked, no further questions) ☐
- 17 months (If checked, no further questions) ☐
- 18 months (If checked, no further questions) ☐
- 19 months (If checked, no further questions) ☐
- 20 months (If checked, no further questions) ☐
- 21 months (If checked, no further questions) ☐
- 22 months (If checked, no further questions) ☐
- 23 months (If checked, no further questions) ☐
- 24 months or longer (If checked, no further questions) ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date