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) ☐
   - Primary (idiopathic) or hypogonadal osteoporosis in a man (If checked, go to 2) ☐
   - Glucocorticoid-induced osteoporosis (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐

   _____
2. Is the request for continuation of therapy? **Y** ☐ **N** ☐
3. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 10) ☐
   - No (If checked, go to 4) ☐
   - Unknown (If checked, go to 10) ☐
4. How long has the patient been receiving therapy with the requested drug?
   - Less than 24 months (If checked, go to 5) ☐
   - 24 months or more (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 (e.g., 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) ☐

7. Has the patient remained at or returned to having a high risk for fracture? **Y** ☐ **N** ☐

8. Has the patient experienced clinical benefit (i.e., improvement or stabilization in T-score since the previous bone mass measurement)? **Y** ☐ **N** ☐

9. Has the patient experienced any adverse effects? **Y** ☐ **N** ☐

10. What is the indication?

Postmenopausal osteoporosis (If checked, go to 11) ☐

Primary (idiopathic) or hypogonadal osteoporosis in men (If checked, go to 20) ☐

Glucocorticoid-induced osteoporosis (If checked, go to 27) ☐

11. 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

12. What is the patient's pre-treatment T-score? Please provide 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 15) ☐

_____

Between -2.5 and -1 (e.g., -2.4, -2.3, -2) (If checked, go to 13) ☐

_____

-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

13. 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) or medical record.

Greater than or equal to 20% (If checked, go to 15) ☐

_____ Less than 20% (If checked, go to 14) ☐

Unknown (If checked, go to 14) ☐

ACTION REQUIRED: Submit supporting documentation

14. 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) or medical record.

Greater than or equal to 3% (If checked, go to 15) ☐

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

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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

16. 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** ☐

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

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

19. Please indicate the clinical reason to avoid an oral 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 35) ☐

Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) (If checked, go to 35) ☐

Presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders, etc.) (If checked, go to 35) ☐

Inability to stand or sit upright for at least 30 to 60 minutes (If checked, go to 35) ☐

Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink, or medication of the day (If checked, go to 35) ☐

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

History of intolerance to an oral bisphosphonate (If checked, go to 35) ☐

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

20. 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** ☐

21. What is the patient's pre-treatment T-score? Please provide 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 24) ☐

Between -2.5 and -1 (e.g., -2.4, -2.3, -2) (If checked, go to 22) ☐

-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

22. 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) or medical record.

Greater than or equal to 20% (If checked, go to 24) ☐

Less than 20% (If checked, go to 23) ☐

Unknown (If checked, go to 23) ☐

ACTION REQUIRED: Submit supporting documentation

23. 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) or medical record.

Greater than or equal to 3% (If checked, go to 24) ☐

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

Unknown (If checked, no further questions) ☐

ACTION REQUIRED: Submit supporting documentation

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

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

26. Please indicate the clinical reason to avoid 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 35) ☐

Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) (If checked, go to 35) ☐

Presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders) (If checked, go to 35) ☐

Inability to stand or sit upright for 30 to 60 minutes (If checked, go to 35) ☐

Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink, or medication of the day (If checked, go to 35) ☐

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

History of intolerance to an oral or injectable bisphosphonate (If checked, go to 35) ☐

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

27. Is the patient currently receiving or will be initiating glucocorticoid therapy at an equivalent prednisone dose of greater than or equal to 2.5 mg/day for greater than or equal to 3 months? **Y** ☐ **N** ☐

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

29. What is the patient's pre-treatment T-score? Please provide 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 32)
    - ☐ Between -2.5 and -1 (e.g., -2.4, -2.3, -2) (If checked, go to 30)
    - ☐ -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

30. 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) or medical record.
    - ☐ Greater than or equal to 20% (If checked, go to 32)
    - ☐ Less than 20% (If checked, go to 31)
    - ☐ Unknown (If checked, go to 31)

    ACTION REQUIRED: Submit supporting documentation

31. 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) or medical record.
    - ☐ Greater than or equal to 3% (If checked, go to 32)
    - ☐ Less than 3% (If checked, no further questions)
    - ☐ Unknown (If checked, no further questions)

    ACTION REQUIRED: Submit supporting documentation

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

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

34. Please indicate the clinical reason to avoid 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 35)

Active upper gastrointestinal problem (e.g., dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers) (If checked, go to 35) ☐

Presence of documented or potential gastrointestinal malabsorption (e.g., gastric bypass procedures, celiac disease, Crohn's disease, infiltrative disorders) (If checked, go to 35) ☐

Inability to stand or sit upright for 30 to 60 minutes (If checked, go to 35) ☐

Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink, or medication of the day (If checked, go to 35) ☐

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

History of intolerance to an oral or injectable bisphosphonate (If checked, go to 35) ☐

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

_____

35. How many months of cumulative parathyroid hormone analog (e.g., teriparatide and abaloparatide) therapy 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, go to 36) ☐

36. Has the patient remained at or returned to having a high risk for fracture? **Y** ☐ **N** ☐

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