BlueCross BlueShield Federal Employee Program.

PARATHYROID HORMONE ANALOGS
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the provider portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Tymlos (abaloparatide)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Will the patient need more than 3 multi-dose prefilled pens every 90 days? ❑Yes***** ❑No
   If YES, please specify the requested quantity: _____ pens per 90 days
2. **MALE Patient**: Does the patient have a diagnosis of osteoporosis? ❑Yes ❑No
3. **FEMALE Patient**: Does the patient have a diagnosis of postmenopausal osteoporosis? ❑Yes ❑No
4. Has the patient been on this medication continuously for the last **6 months** excluding samples or switching from another parathyroid hormone analog (e.g., Bonsity, Forteo, teriparatide)? ❑Yes ❑No*****
   If NO, please answer the following questions:
   a. Does the patient have a history of an osteoporotic low trauma fracture of the spine, hip, proximal humerus, pelvis, or distal forearm? ❑Yes ❑No
   b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to oral or injectable bisphosphonate? ❑Yes ❑No
5. Is the patient at risk for osteosarcoma? ❑Yes ❑No
6. Does the patient have Paget's disease? ❑Yes ❑No
7. Does the patient have unexplained elevations of alkaline phosphatase? ❑Yes ❑No
8. Did the patient have prior bone radiation? ❑Yes ❑No
9. Does the patient have bone metastases or a history of skeletal malignancies? ❑Yes ❑No
10. Does the patient have any metabolic bone diseases other than osteoporosis? ❑Yes ❑No
11. Does the patient have high levels of calcium? ❑Yes ❑No
12. Has the patient used any parathyroid hormone analog (e.g., Bonsity, Forteo, teriparatide, Tymlos) for longer than 24 months? ❑Yes ❑No
    ****Parathyroid Hormone Analogs: Bonsity, (teriparatide), Forteo (teriparatide), Teriparatide (teriparatide), Tymlos (abaloparatide)***
13. Will this medication be used in combination with other *****human parathyroid hormone related peptide analogs or another *****prior authorization (PA) medication for osteoporosis? ❑Yes***** ❑No
    If YES, please specify the medication: _____
    ****Human Parathyroid Hormone Related Peptide Analogs/PA Osteoporosis Medications: Bonsity, (teriparatide), Evenity (romosuzumab-aggg), Forteo (teriparatide), Prolia (denosumab), Teriparatide (teriparatide), Tymlos (abaloparatide)***

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***