US Family Health Plan

Prior Authorization Request Form for

Abaloparatide (Tymlos)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required for approval
Prior authorization expires after 24 months

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Forteo is the Department of Defense's preferred osteoporosis Parathyroid hormone (PTH) analog. Has the patient tried Forteo?	☐ Yes Proceed to question **3**	☐ No Proceed to question **2**
2. Is the patient able to comply with the refrigeration requirement for Forteo?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **3**
3. Is the requested medication prescribed for treatment of osteoporosis, and not for prevention of osteoporosis?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient a male OR postmenopausal female with osteoporosis?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient at a high risk for fracture due to history of osteoporotic fracture, OR has multiple risk factors for fracture (for example: a history of vertebral fracture or low-trauma fragility fracture of the hip, spine or pelvis, distal forearm or proximal humerus)?	☐ Yes Proceed to question **8**	☐ No Proceed to question **6**
6. Does the patient have a documented bone mineral density (BMD) T-score of -2.5 or worse?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**

7. Has the patient tried and experienced an inadequate response to, therapeutic failure with, is intolerant to (unable to use or absorb), or has contraindications to at least one formulary osteoporosis therapy (for example: alendronate, ibandronate)?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Will the patient continue to take calcium and vitamin D supplementation during PTH analog therapy if dietary intake is inadequate?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Will cumulative treatment with Tymlos, Forteo or other Parathyroid Hormone Analogs formulations exceed 24 months during the patient's lifetime?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **10**
10. Is the patient at increased risk for osteosarcoma (for example: Paget's disease, unexplained elevations of alkaline phosphatase, patients with open epiphyses, prior external beam or implant radiation therapy involving the skeleton)?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____