PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Tymlos - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Tymlos - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Tymlos (abaloparatide)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 13.]

2. Does the patient have a diagnosis of postmenopausal osteoporosis? Y N

	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
3.	Does the patient have a Bone Mineral Density (BMD) T-score of -2.5 or below in the lumbar spine, femoral neck, hip, and/or 33% (one-third) radius?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
4.	Is the patient defined as being at high risk of fracture?	Y N
	[If no, no further questions.]	
5.	Does the patient have a history of previous osteoporotic (fragility) fracture (fracture of the spine, hip, proximal humerus, pelvis, or distal forearm) regardless of T-score?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
6.	Does the patient have a T-score between -1.0 and -2.5 in the spine, femoral neck, hip, or 33% radius?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
7.	Does the patient have a Fracture Risk Assessment (FRAX) 10-year probability for major osteoporotic fracture or 20% or greater, or the 10-year probability of hip fracture or 3% or greater?	Y N
	NOTE: Submission of medical records is required.	
	[If yes, skip to question 9.]	
8.	Does the patient have a history of repeat falls?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
9.	Does the patient have a documented treatment failure or contraindication to conventional osteoporosis therapy (two independent bisphosphonate regimens)?	Y N
	NOTE: Submission of medical records is required.	
	[If no, no further questions.]	
10.	Is the patient 18 years of age or older?	Y N
	[If no, no further questions.]	
11.	Is the patient a female?	Y N
	[If no, no further questions.]	
12.	Has the patient been on therapy with the requested agent for more than 2 years of cumulative therapy during the patient's lifetime?	Y N
	[No further questions.]	

13. Has the patient shown clinical benefit from treatment? (Clinical benefit is evidenced by stable or increasing BMD with no display of new fractures or fracture progression)	Y N
NOTE: Submission of medical records is required.	
[If no, no further questions.]	
14. Has the patient been on therapy with the requested agent for more than 2 years of cumulative therapy during the patient's lifetime?	Y N
[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