Prior Authorization Request Form for
abaloparatide (Tymlos)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

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 **2**	☐ No Proceed to question **10**
2. Is the requested medication prescribed for treatment of osteoporosis, and not for prevention of osteoporosis?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient a postmenopausal female with osteoporosis?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the patient at a high risk for fracture due to history of osteoporotic fracture, OR has multiple risk factors for fracture (e.g., 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 **7**	☐ No Proceed to question **5**
5. Does the patient have a documented bone mineral density (BMD) T-score of -2.5 or worse?	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**
6. 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 (e.g., alendronate, ibandronate)?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Will the patient continue to take calcium and vitamin D supplementation during PTH analog therapy if dietary intake is inadequate?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

Prior Authorization Request Form for
abaloparatide (Tymlos)

8. Will cumulative treatment with Tymlos and Forteo exceed 24 months during the patient's lifetime?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **9**
9. Is the patient at increased risk for osteosarcoma (e.g., 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**
10. Is the patient able to comply with the refrigeration requirement for Forteo?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **11**
11. Is the requested medication prescribed for treatment of osteoporosis, and not for prevention of osteoporosis?	☐ Yes Proceed to question **12**	☐ No **STOP** **Coverage not approved**
12. Is the patient a postmenopausal female with osteoporosis?	☐ Yes Proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient at a high risk for fracture due to history of osteoporotic fracture, OR has multiple risk factors for fracture (e.g., 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 **16**	☐ No Proceed to question **14**
14. Does the patient have a documented bone mineral density (BMD) T-score of -2.5 or worse?	☐ Yes Proceed to question **16**	☐ No Proceed to question **15**
15. 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 (e.g., alendronate, ibandronate)?	☐ Yes Proceed to question **16**	☐ No **STOP** **Coverage not approved**
16. Will the patient continue to take calcium and vitamin D supplementation during PTH analog therapy if dietary intake is inadequate?	☐ Yes Proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Will cumulative treatment with Tymlos and Forteo exceed 24 months during the patient's lifetime?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **18**
18. Is the patient at increased risk for osteosarcoma (e.g., 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**

TRICARE Prior Authorization Request Form for
abaloparatide (Tymlos)

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

_____ _____

Prescriber Signature Date

[13 November 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: