Forteo, Teriparatide, Bonsity

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: ______________________________**Date**: _________________________________
Patient's ID: _______________________________**Patient's Date of Birth:** ________________
Physician's Name: ____
Specialty: __________________________________ **NPI#:** __________________________________
Physician Office Telephone: __________________**Physician Office Fax:** ___________________
Request Initiated For: _______________________

1. What is the prescribed drug? ❑ Teriparatide ❑ Forteo ❑ Bonsity
2. What is the indication?
   ❑ Postmenopausal osteoporosis
   ❑ Primary (idiopathic) or hypogonadal osteoporosis in men
   ❑ Glucocorticoid-induced osteoporosis
   ❑ Other ____
3. What is the ICD-10 code? _____________
4. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #12*
5. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #12* ❑ Yes ❑ No ❑ Unknown
6. How long has the patient been receiving therapy with the requested drug?
   ❑ Less than 24 months ❑ 24 months or more, *Skip to #9*
7. Has the patient experienced clinically significant adverse events during therapy? ❑ Yes ❑ No
8. How many months of cumulative parathyroid hormone analog therapy has the patient received in their lifetime?
   ❑ Less than 12 months ❑ 12 months ❑ 13 months ❑ 14 months ❑ 15 months ❑ 16 months ❑ 17 months
   ❑ 18 months ❑ 19 months ❑ 20 months ❑ 21 months ❑ 22 months ❑ 23 months *No further questions.*
9. Has the patient remained at or returned to having a high risk for fracture? ❑ Yes ❑ No
10. Has the patient experienced clinical benefit (i.e., improvement or stabilization in T-score since the previous bone mass measurement)? ❑ Yes ❑ No
11. Has the patient experienced any adverse effects? ❑ Yes ❑ No *No further questions.*
12. How many months of cumulative parathyroid hormone analog (e.g., Forteo, Bonsity, teriparatide, or Tymlos) therapy has the patient received in their lifetime? *If 23 months or less, skip to #14*
    ❑ Less than 12 months ❑ 12 months ❑ 13 months ❑ 14 months ❑ 15 months ❑ 16 months ❑ 17 months
    ❑ 18 months ❑ 19 months ❑ 20 months ❑ 21 months ❑ 22 months ❑ 23 months ❑ 24 months or longer

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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13. Has the patient remained at or returned to having a high risk for fracture? ❑ Yes ❑ No

14. 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.***
________ ❑ Unknown *If -2.5 or below (e.g., -2.6, -2.7, -3), skip to #17*

15. 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). ____________ % ❑ Unknown
If greater than or equal to 20%, skip to #17

16. 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).____________ % ❑ Unknown

17. Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate?
If Yes, skip to diagnosis section. ❑ Yes - oral bisphosphonate ❑ Yes - injectable bisphosphonate ❑ No

18. Is there a clinical reason to avoid treatment with a bisphosphonate? ❑ Yes ❑ No
If Yes, please indicate reason: ____

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Postmenopausal Osteoporosis

19. Does the patient have a history of fragility fractures? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical record and no further questions.*** ❑ Yes ❑ No

20. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], denosumab [Prolia], abaloparatide [Tymlos]?
If Yes, no further questions. ❑ Yes ❑ No

21. 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)? ❑ Yes ❑ No

Section B: Primary (Idiopathic) or Hypogonadal Osteoporosis in Men

22. 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.*** ❑ Yes ❑ No

Section C: Glucocorticoid-Induced Osteoporosis

23. 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? ❑ Yes ❑ No

24. Does the patient have a history of a fragility fracture? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical record.*** ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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