CVS caremark™ {{PANUMCODE}}

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID: {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the prescribed drug? ❑ Forteo ❑ Teriparatide ❑ Bonsity

2. What is the indication?
   ❑ Postmenopausal osteoporosis
   ❑ Primary (idiopathic) or hypogonadal osteoporosis
   ❑ Glucocorticoid-induced osteoporosis
   ❑ Other _____

3. What is the ICD-10 code? _____

Section A: Preferred Product - Forteo and Bonsity Requests

4. Is the requested product being prescribed for the treatment of osteoporosis in a postmenopausal woman at high risk for fracture? ❑ Yes ❑ No *If No, skip to Section B: All Requests.*

5. The preferred product for your patient's health plan is Tymlos. Can the patient's treatment be switched to the preferred product? ***If Yes, please call 1-866-814-5506 to have the updated form faxed to your office OR you may complete the PA electronically (ePA). You may sign up online via CoverMyMeds at: www.covermymeds.com/epa/caremark/ or call 1-866-452-5017.*** ❑ Yes ❑ No

6. Has the patient received cumulative treatment with Tymlos exceeding 24 months in the patient's lifetime? *If Yes, skip to Section B: All Requests.* ❑ Yes ❑ No

7. Has the patient experienced at least one of the following to the preferred product, Tymlos?
   ACTION REQUIRED: If Yes, attach supporting chart notes(s).
   ❑ Yes - A documented inadequate response to treatment
   ❑ Yes - A documented intolerable adverse event
   ❑ Yes - A documented contraindication to therapy
   ❑ No *If No, complete this form in its entirety and State Step Therapy section.*

Section B: All Requests

8. How many months of cumulative parathyroid hormone analogs (e.g., Forteo, Bonsity, Teriparatide, or Tymlos) therapy has the patient received in their lifetime? _____ months

9. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #14*

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10. Is the patient currently receiving the requested drug through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #14* ❑ Unknown ❑ Yes ❑ No

11. Has the patient experienced clinical benefit as evidenced by a bone mass measurement showing an improvement or stabilization in T-score compared with the previous bone mass measurement?
❑ Yes ❑ No *If No, skip to #13*

12. Has the patient experienced any adverse effects? ❑ Yes ❑ No

13. Has the patient experienced clinical benefit as evidenced by no adverse events during therapy (i.e., no clinically significant adverse reaction to the requested drug, no new fracture seen on radiography)?
❑ Yes ❑ No *No further questions*

14. What is the patient's pretreatment T-score? *Please provide the patient's T-score prior to initiation of osteoporosis treatment.* ***ACTION REQUIRED: Attach supporting chart note(s).*** _____ ❑ Unknown
If less than or equal to -2.5 (ex. -3, -4), skip to #17

15. What is the patient's pre-treatment FRAX score for any major fracture? (See Appendix). *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment.* ***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 FRAX score for hip fracture? (See Appendix). *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment.* ***ACTION REQUIRED: Attach supporting chart note(s).*** _____ % ❑ Unknown

17. Has the patient had at least a 1-year trial of an oral bisphosphonate OR injectable bisphosphonate?
If Yes, skip to diagnosis section ❑ Yes ❑ 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 C: Postmenopausal Osteoporosis

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

20. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (i.e., 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 [less than or equal to -3], increased fall risk)? ❑ Yes ❑ No

Section D: Primary (Idiopathic) or Hypogonadal Osteoporosis

22. Does the patient have a history of an osteoporotic vertebral or hip fracture? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

Section E: 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).*** ❑ Yes ❑ No

Appendix:

*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 per day.

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Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? ❑ Yes ❑ No
2. Does the prescribed dose and quantity fall within the FDA-approved labeling or within dosing guidelines found in the compendia of current literature? ❑ Yes ❑ No
3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*
4. Is the alternate drug (Tymlos) FDA-approved for the medical condition being treated?
   ❑ Yes ❑ No *If No, please specify:* _____
5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*
6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*
7. Are any of the following conditions met for the alternate drug (Tymlos)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction or physical or mental harm or decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ Use of the alternate drug is not in the patient's best interest
   ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
   ❑ None of the above
   If Yes, please specify: _____
8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient?
   If Yes, no further questions ❑ Yes ❑ No
9. Is the requested prescription drug necessary to save the life of the patient? ❑ 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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 Forteo, Teriparatide, Bonsity State Step, Marketplace SGM - 1/2022.