

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



{{PANUMCODE}}

Tymlos

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: {{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}}

- What is the indication?
 Postmenopausal osteoporosis
 Other _____
- What is the ICD-10 code? _____
- Is the request for continuation of therapy? Yes No *If No, skip to #8*
- Is the patient currently receiving Tymlos through samples or a manufacturer's patient assistance program?
If Yes or Unknown, skip to #8 Yes No Unknown
- Has the patient received previous therapy with Forteo or Bonsity in their lifetime?
If Yes, skip to #7 Yes No
- How many months has the patient received therapy with Tymlos? _____ months *No further questions*
- How many months of cumulative parathyroid hormone analogs (e.g., Forteo, Bonsity, or Tymlos) therapy has the patient received in their lifetime? _____ months *No further questions*
- Does the patient have a history of fragility fractures? **ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #15.** Yes No
- What is the patient's pre-treatment T-score? **ACTION REQUIRED: Attach supporting chart note(s).**
_____ Unknown
If T-score is -2.5 or below (e.g., -2.6, -2.7, -3), skip to #11.
- What is the patient's pre-treatment FRAX score for the following? **ACTION REQUIRED: Attach supporting chart note(s).** (See Appendix below).
Major fracture: _____% Unknown
Hip fracture: _____% Unknown
- Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], denosumab [Prolia])? *If Yes, skip to #15* Yes No
- Has the patient had at least a 1-year trial of an oral bisphosphonate? *If Yes, skip to #15* Yes No

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

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13. Is there a clinical reason to avoid treatment with an oral bisphosphonate? Yes No

If Yes, indicate reason: _____

14. Does the patient have any indicators of higher fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores [less than or equal to -3.5], increased fall risk)? Yes No

15. Has the patient received any parathyroid hormone analogs (e.g., Forteo, Bonsity, or Tymlos) in their lifetime? Yes No *If No, no further questions*

16. How many months of cumulative parathyroid hormone analogs (such as Tymlos or Forteo) therapy has the patient received in their lifetime? _____ months

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 and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day.

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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