

# FORTEO & TYMLOS AUTHORIZATION AND RE- AUTHORIZATION REQUEST

Member Name:		Today's Date:	
Date of birth:	Sex:	Weight:	Prescriber: Specialty:
Home Phone Number:		Phone Number:	Fax Number:
Home Address/City/State/Zip:		Address/City/State/Zip:	
Payor:	<input type="checkbox"/> Commercial <input type="checkbox"/> Medicare	Office Contact:	
<input type="checkbox"/> Independent Health	<input type="checkbox"/> Medicaid <input type="checkbox"/> Self-funded	Allergies:	
<input type="checkbox"/> Anne Arundel Health System		<input type="checkbox"/> Medication ships to patient's home	
<input type="checkbox"/> Pharmacy Benefit Dimensions		<input type="checkbox"/> Medication ships to provider's office	
Insurance ID:	Group Number:		

**DRUG SELECTION:**

- New Authorization  Re-authorization Request  
 **Tymlos**  **Forteo**  **Teriparatide**

Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_  
 Will medication be self-injected?  Yes  No

**STATEMENT OF MEDICAL NECESSITY:**

Primary Diagnosis: \_\_\_\_\_

ICD10 Code: \_\_\_\_\_

Prior Treatments: \_\_\_\_\_

Current Treatment: \_\_\_\_\_

Has patient tried and failed to tolerate or respond to (or have a contraindication to) treatment with preferred formulary medication? (bisphosphates, RANK-Ligand inhibitors, Estrogen agonist/antagonist, calcitonin)  Yes  No

Female patient post-menopausal?  Yes  No

Does patient have any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Paget's disease of the bone?                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Open epiphyses   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Pre-existing hypercalcemia                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Bone metastases or a history of skeletal malignancies? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Prior radiation therapy involving skeleton?            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Hereditary disorders predisposing to osteosarcoma      | <input type="checkbox"/> Yes <input type="checkbox"/> No |

Will patient receive concurrent Vitamin D and calcium supplements?  Yes  No

Patient has a history of osteoporotic fracture?  Yes  No

**OR at least two of the following:**

- History of frequent falls
- Bone density t-score more than 2.5 standard deviations below the mean  
If yes: T-Score \_\_\_\_\_ Date \_\_\_\_\_
- Limited movement, such as using a wheelchair
- Medical conditions likely to cause bone loss or increase the risk of fracture  
If yes please list \_\_\_\_\_
- Concurrent use of medications that may cause bone loss  
If yes please list \_\_\_\_\_
- Concurrent use of medications that increase the risk of falls  
If yes please list \_\_\_\_\_