



Please complete ALL information below and fax your request to 1-888-671-5285

Tymlos™ Prior Authorization Request Form

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Member Information (required) Provider Information (required)

Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)

Select the diagnosis below:

Postmenopausal women with osteoporosis at high risk of fracture

Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Does the patient have postmenopausal osteoporosis or osteopenia? Yes No

Does the patient have a bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)? Yes No

Does the patient have a history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm? Yes No

Has the patient had trial and failure, contraindication, or intolerance to one osteoporosis treatment [e.g., alendronate, risedronate, zoledronic acid, Prolia (denosumab)]? Yes No

Does the patient have a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)? Yes No

If "yes" to the above question, select if the patient has the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities:

Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions

Hip fracture is 3% or more in the U.S., or the country-specific threshold in other countries or regions

Has the patient's treatment duration of parathyroid hormones [Forteo (teriparatide), Tymlos (abaloparatide)] exceeded a total of 24 months during the patient's lifetime? Yes No

Please document the number of months of parathyroid hormone therapy the patient has used in his/her lifetime: _____ months

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

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