FUTURE SCRIPTS

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

Tymlos™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

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.