HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
OSTEOPROSIS MEDICATIONS
Evenity®, Forteo®, Tymlos®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Evenity® (romosozumab), ☐ teriparatide, ☐ Tymlos® (abaloparatide)
Non-preferred: ☐ Forteo® (teriparatide)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Does the member have a documented diagnosis of one of the following: • Postmenopausal female patient with osteoporosis, • Male with primary or hypogonadal osteoporosis, • Osteoporosis likely caused by systemic glucocorticoid therapy?	☐	☐	**Please provide documentation**
2. Is the member considered high risk for fracture, defined by meeting one of the following: • History of recent fragility fracture or bone mineral density measurement showing osteoporosis (T-score ≤ -2.5), • History of previous fractures and/or glucocorticoid use for at least 3 months and osteopenia (T-Score between -1 and -2.5)?	☐	☐	**Please provide documentation**
3. Does the member have severe osteoporosis, defined as one of the following: • T-score ≤ -2.5 plus a recent fragility fracture • T-score ≤ -3.5 and at high risk for fragility fracture based on FRAX score	☐	☐	**Please provide documentation**
4. Does documentation show a 24-month trial and failure (defined as progression of bone loss) of at least one bisphosphonate (i.e.	☐	☐	**Please provide documentation**

alendronate, ibandronate, risedronate, intravenous zoledronic acid), unless contraindicated? • IV therapy (zoledronic acid) is required if the member is unable to tolerate oral bisphosphonate or has an absorption disorder.			
5. Does documentation show a 24-month trial and failure of intravenous Prolia®, unless contraindicated?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

PHARM- 054
Origination Date: 08/07/2017
Reviewed/Revised Date: 05/20/2020
Next Review Date: 05/20/2021
Current Effective Date: 06/01/2020