



OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations. Visit go.covermymeds.com/OptumRx to begin using this free service. Please note: All information below is required to process this request. Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

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:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Postmenopausal women with osteoporosis at high risk for fracture	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical Information:	
Does the patient have a diagnosis of postmenopausal osteoporosis or osteopenia? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please document the patient's bone mineral density (BMD) T-score measured from the lumbar spine, femoral neck, total hip, or radius (one-third radius site): _____ (specify if negative)	
Does the patient have history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient had trial and failure, contraindication, or intolerance to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Select if the patient has the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities:	
<input type="checkbox"/> Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions	
<input type="checkbox"/> Hip fracture is 3% or more in the U.S., or the country-specific threshold in other countries or regions	
Has treatment duration with parathyroid hormones [e.g., Forteo (teriparatide), Tymlos (abaloparatide)] exceeded 24 months during the patient's lifetime? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Quantity Limit:	
What is the quantity requested per MONTH? _____ mL	
What is the reason for exceeding the plan limitations?	
<input type="checkbox"/> Titration or loading-dose purposes	
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)	
<input type="checkbox"/> Requested strength/dose is not commercially available	
<input type="checkbox"/> There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: _____	
<input type="checkbox"/> Other: _____	

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. If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

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