UnitedHealthcare Community Plan

Forteo/Tymlos – Virginia
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication □ New or □ Continuation of Therapy? If continuation, list start date: ________________
Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ________________

Section B - Physician Information				
First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information	
Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Is this member pregnant? □ Yes □ No **If yes, what is this member's due date?** ________________	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

- **Does the patient have a confirmed diagnosis of osteoporosis? □ Yes □ No**

- **Has the patient experienced a therapeutic failure or inadequate response to at least 2 bisphosphonates? □Yes □No**
  If yes, must complete section D above with medications tried and dates of therapy.

- **Is the patient unable to receive or have a contraindication to a bisphosphonate? □ Yes □ No**
  If yes, list reasons/contraindications:____

- **Is the patient a male requiring an increase of bone mass with primary or hypogonadal osteoporosis and is at high risk for fractures? □ Yes □ No**

- **Will the patient be taking calcium and vitamin D supplementation if dietary intake is inadequate? □ Yes □ No**

- **Does the patient have a documented Hip DXA (femoral neck or total hip) or lumbar spine T-score -2.5 (standard deviations) or below? □ Yes □ No**
  If yes, list score and date completed: ______________________________

- **Is the patient a postmenopausal woman with two or more of the following clinical risk factors? □ Yes □ No**
  If yes, check all that apply:
  - □ Family history of non-traumatic fracture(s)
  - □ DXA BMD T-score ≤ -2.5 at any site
  - □ Chronic glucocorticoid use (≥ 6 months of use at 7.5 mg/day dose of prednisolone equivalent)
  - □ Rheumatoid arthritis
  - □ Current smoker
  - □ More than two alcoholic beverages per day

- **Does the patient have a bone mineral density of -3 or worse? □ Yes □ No**

- **Is that patient a postmenopausal woman with history of non-traumatic fracture(s)? □ Yes □ No**

- **Is the patient at increased risk for osteosarcoma (e.g., Paget's disease of bone, bone metastases or skeletal malignancies, etc.)? □ Yes □ No**
  If yes, list reason for increased risk: ____
  ____

- **Has the patient already received 24 months of lifetime therapy with parathyroid hormone analogs (Forteo and/or Tymlos)? □ Yes □ No**

Physician Signature: ______________________________ **Date:** ______________

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Website: uhccommunityplan.com