UnitedHealthcare Community Plan

# Tymlos
## 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 diagnosis of osteoporosis? □ Yes □ No**

**- What is the patient's BMD T-score based on BMD measurements from lumber spine, hip, or radius? (check which apply)** **Please submit patient specific BMD-T score**

□ Less than or equal to -3.5
□ Between -2.5 and -3.5 (greater than -3.5 and less than or equal to -2.5)
□ Between -1 and -2.5 (greater than -2.5 and less than or equal to -1)
□ Greater than -1
□ Other, List diagnosis: _____

**- Does the patient have a history of any of the following resulting from minimal trauma: □ Yes □ No (check all that apply)**

□ Vertebral compression fracture
□ Fracture of the hip
□ Fracture of the distal radius
□ Fracture of the pelvis
□ Fracture of the proximal humerus; List: _____

**- Does the patient have a history of failure, contraindication, or intolerance to a conventional osteoporosis therapy? □ Yes □ No**
(If yes, complete Section D above with medication information, including dose, duration, and date of trial)

**- Does the patient have either of the following FRAX 10-year probabilities? □ Yes □ No (check which apply)**
□ Major osteoporotic fracture at 20% or more □ Hip fracture at 3% or more

**- Has the treatment duration exceeded a total of 24 months of cumulative use of parathyroid hormone analogs during the patient's lifetime? □ Yes □ No**
If no, list how many months patient has already received of parathyroid hormone analogs: _____

□ ***The prescriber attests to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.***

**Physician Signature:** _____ **Date:** _____