



Service Authorization (SA) Form

**FORTEO®, teriparatide or TYMLOS™**

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

**MEMBER INFORMATION**

Last Name:

First Name:

Medicaid ID Number:

Date of Birth:

Weight in Kilograms: \_\_\_\_\_

**PRESCRIBER INFORMATION**

Last Name:

First Name:

NPI Number:

Phone Number:

Fax Number:

**DRUG INFORMATION**

Drug Name/Form: \_\_\_\_\_

Strength: \_\_\_\_\_

Dosing Frequency: \_\_\_\_\_

Length of Therapy: \_\_\_\_\_

Quantity per Day: \_\_\_\_\_

*(Form continued on next page.)*

Member's Last Name:

Member's First Name:

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**DIAGNOSIS AND MEDICAL INFORMATION**

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1. Is the member 18 or older?

☐ Yes ☐ No

2. Does the member have a confirmed diagnosis of osteoporosis?

☐ Yes ☐ No

3. Has the member experienced a therapeutic failure or inadequate response to at least two bisphosphonates?

☐ Yes ☐ No

If **No**, is the member unable to receive or have a contraindication to a bisphosphonate?

☐ Yes ☐ No

List details: \_\_\_\_\_

4. Is the member assigned male at birth requiring increased bone mass with primary or hypogonadal osteoporosis?

☐ Yes ☐ No

5. Is the member at a high risk for fractures?

☐ Yes ☐ No

6. Will the member be taking calcium and vitamin D supplementation if dietary intake is inadequate?

☐ Yes ☐ No

7. Does the member have a documented Hip DXA (femoral neck or total hip) or lumbar spine T-score -2.5 (standard deviations) or below?

☐ Yes ☐ No

8. Does the member have Bone Mineral Density (BMD) of -3 or worse?

☐ Yes ☐ No

9. Is the member postmenopausal with history of non-traumatic fracture(s)?

☐ Yes ☐ No

*(Form continued on next page.)*

**Member's Last Name:**

**Member's First Name:**

10. Is the member post-menopausal with two or more of the following clinical risk factors:

- ☐ Family history of non-traumatic fracture(s)
- ☐ DXA BMD T-score  $\leq -2.5$  at any site
- ☐ More than 2 alcohol beverages per day
- ☐ Glucocorticoid use ( $\geq 6$  months of use at 7.5 dose of prednisolone equivalent)
- ☐ History of non-traumatic fracture(s)
- ☐ Rheumatoid Arthritis
- ☐ Current smoker

11. Member is not at increased risk for osteosarcoma (e.g., Paget's disease of bone, bone metastases or skeletal malignancies, etc.)?

- ☐ Yes      ☐ No

12. Member has not received therapy with parathyroid hormone analogs (e.g., Forteo) in excess of 24 months in total?

- ☐ Yes      ☐ No

**Prescriber Signature (Required)**

**Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

**Please include ALL requested information; Incomplete forms will delay the SA process.**

Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

Fax this form to 1-866-940-7328

Pharmacy PA call center: 1-800-310-6826