Member Name: {{MEMFIRST}} {{MEMLAST}} **DOB:** {{MEMBERDOB}} **PA Number:** {{PANUMBER}}

CVS caremark™ {{PANUMCODE}}

Tymlos

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date**: {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, NPI#: _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

1. What is the indication?
   ❑ Postmenopausal osteoporosis
   ❑ Other _____
2. What is the ICD-10 code? _____
3. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #9*
4. Is the patient currently receiving Tymlos through samples or a manufacturer's patient assistance program?
   If Yes or Unknown, skip to #9 ❑ Yes ❑ No ❑ Unknown
5. Has the patient experienced clinical benefit as evidenced by a bone mass measurement showing an improvement or stabilization in T-score compared with the previous bone mass measurement? ❑ Yes ❑ No *If No, skip to #7*
6. Has the patient experienced any adverse effects? ❑ Yes ❑ No *If No, skip to #8*
7. Has the member experienced clinical benefit as evidenced by no adverse events during therapy (i.e., no clinically significant adverse reaction to Tymlos, no new fracture seen on radiography)? ❑ Yes ❑ No
8. How many months of cumulative parathyroid hormone analogs therapy has the patient received in their lifetime?
   _____ months *No further questions*
9. Does the patient have a history of fragility fractures? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and skip to #16.*** ❑ Yes ❑ No
10. What is the patient's pre-treatment T-score? ***ACTION REQUIRED: Attach supporting chart note(s).***
    _____ ❑ Unknown
    If T-score is -2.5 or below (*e.g., -2.6, -2.7, -3*), skip to #12.
11. What is the patient's pre-treatment FRAX score for the following? ***ACTION REQUIRED: Attach supporting chart note(s).*** (See Appendix below).
    Major fracture: _____% ❑ Unknown
    Hip fracture: _____% ❑ Unknown

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

12. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], denosumab [Prolia])? *If Yes, skip to #16* ❑ Yes ❑ No
13. Has the patient had at least a 1-year trial of an oral bisphosphonate? *If Yes, skip to #16* ❑ Yes ❑ No
14. Is there a clinical reason to avoid treatment with an oral bisphosphonate? ❑ Yes ❑ No
    If Yes, indicate reason: _____
15. Does the patient have any indicators of very high fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores [-3 or below], increased fall risk)? ❑ Yes ❑ No
16. How many months of cumulative parathyroid hormone analogs therapy (teriparatide and abaloparatide) has the patient received in their lifetime? _____ months

Appendix:

- *Calculator available at https://www.sheffield.ac.uk/FRAX/
- The estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture (including fractures of the spine (clinical), hip, wrist, or humerus) and 1.2 for hip fracture if glucocorticoid treatment is greater than 7.5 mg (prednisone equivalent) per day.

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155