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 diagnosis?
   - ❑ Postmenopausal osteoporosis
   - ❑ Osteoporosis in a man
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. How many months of cumulative parathyroid hormone analog therapy (teriparatide and abaloparatide) has the patient received in their lifetime? _____ month(s)
4. Is the request for continuation of therapy? ❑ Yes ❑ No *If No, skip to #7*
5. Is the patient currently receiving Tymlos through samples or a manufacturer's patient assistance program? *If Yes or Unknown, skip to #7* ❑ Yes ❑ No ❑ Unknown
6. Has the patient experienced clinically significant adverse events during therapy? ❑ Yes ❑ No *No further questions.*
7. What is the patient's pre-treatment T-score? ***ACTION REQUIRED: Attach supporting chart note(s) or medical record.*** *Indicate the patient's T-score prior to initiation of osteoporosis treatment.* _____ ❑ Unknown
8. What is the patient's pre-treatment Fracture Risk Assessment Tool (FRAX) score* for the following? ***ACTION REQUIRED: Attach supporting chart note(s) or medical records.*** (See Appendix below).
   Major fracture: _____% ❑ Unknown
   Hip fracture: _____% ❑ Unknown

   *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.

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

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

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Postmenopausal Osteoporosis

9. Does the patient have a history of fragility fractures? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical records.*** *If Yes, no further questions.* ❑ Yes ❑ No

10. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], denosumab [Prolia])? *If Yes, no further questions.* ❑ Yes ❑ No

11. 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)? *If Yes, no further questions.* ❑ Yes ❑ No

12. Has the patient had at least a 1-year trial of an oral bisphosphonate? *If Yes, no further questions.* ❑ Yes ❑ No

13. Is there a clinical reason to avoid treatment with an oral bisphosphonate?
If Yes, no further questions. ❑ Yes ❑ No
If Yes, indicate reason: _____

Section B: Osteoporosis in a Man

14. Does the patient have a history of an osteoporotic vertebral or hip fracture? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) or medical record.*** *If Yes, no further questions.* ❑ Yes ❑ No

15. Has the patient had at least a 1-year trial of an oral OR injectable bisphosphonate?
If Yes, no further questions. ❑ Yes ❑ No

16. Is there a clinical reason to avoid treatment with a bisphosphonate? ❑ Yes ❑ No
If Yes, indicate reason: _____

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