OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete forms will delay the authorization process**.

Drug Requested: (select applicable drug below) **(Non-Preferred)**	
❑ **Forteo®** (teriparatide)	❑ **Tymlos™** (abaloparatide)

DRUG INFORMATION: Complete information below or authorization process will be delayed.

Dosage Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: **ALL** boxes **must** be checked to qualify or authorization process will be delayed.

Initial Approval Authorization: 1 Year

1. Is the patient 18 years or older? ❑ Yes ❑ No
2. Does the patient have a confirmed diagnosis of osteoporosis? ❑ Yes ❑ No
3. Has the patient experienced a therapeutic failure or inadequate response to at least two bisphosphonates? ❑ Yes ❑ No
4. Is the patient a male requiring increased bone mass with primary or hypogonadal osteoporosis? ❑ Yes ❑ No
5. Is the patient at a high risk for fractures? ❑ Yes ❑ No
6. Will the patient be taking calcium and vitamin D supplementation if dietary intake is inadequate? ❑ Yes ❑ No
7. 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
8. Does the patient have Bone Mineral Density (BMD) of -3 or worse? ❑ Yes ❑ No
9. Is the patient a postmenopausal woman with history of non-traumatic fracture(s)? ❑ Yes ❑ No
10. Is the patient a postmenopausal woman with two or more of the following clinical risk factors? ❑ Yes ❑ No

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

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11. Patient is not at increased risk for osteosarcoma (e.g., Paget's disease of bone, bone metastases or skeletal malignancies, etc.) ❑ Yes ❑ No
12. Patient has not received therapy with parathyroid hormone analogs (e.g., Forteo) in excess of 24 months in total ❑Yes ❑ No

Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Member Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: ~~6/30/2017; 8/29/2017;~~ **8/20/2018**