

# OPTIMA HEALTH COMMUNITY CARE

## 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 1-800-319-5003. 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) [MEDICAID](#)

<input type="checkbox"/> <b>Forteo®</b> (teriparatide)	<input type="checkbox"/> <b>Tymlos™</b> (abaloparatide)
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**DRUG INFORMATION:** Complete information below. If incomplete, 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**

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

<input type="checkbox"/> Family history of non-traumatic fracture(s)	<input type="checkbox"/> History of non-traumatic fracture(s)
<input type="checkbox"/> DXA BMD T-score $\leq$ -2.5 at any site	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> More than 2 alcohol beverages per day	<input type="checkbox"/> Current smoker
<input type="checkbox"/> Glucocorticoid use* ( $\geq$ 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.) | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 12. Patient has not received therapy with parathyroid hormone analogs (e.g., Forteo) in excess of 24 months in total                  | <input type="checkbox"/> Yes <input type="checkbox"/> 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 #: \_\_\_\_\_