



# Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

## Tymlos® (abaloparatide) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand <input type="checkbox"/> Check if request is for initial therapy <input type="checkbox"/> Check if request is for recertification of therapy			Directions for Use:		
Clinical Information (required)					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Diagnosis of postmenopausal osteoporosis or osteopenia <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Drug-Specific Information (required)					
<input type="checkbox"/> The recipient's Bone Mineral Density (BMD) T-score is -2.5 or lower in the lumbar spine, femoral neck, total hip or radius (one-third radius site). <input type="checkbox"/> The recipient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site). <input type="checkbox"/> The recipient has documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis or distal forearm. <input type="checkbox"/> The recipient has documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia® [denosumab]). <input type="checkbox"/> The recipient has a FRAX 10-year probability of a major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions. <input type="checkbox"/> The recipient has a FRAX 10-year probability of a hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions. <input type="checkbox"/> The recipient's treatment duration of parathyroid hormones has not exceeded a total of 24 months during their lifetime.					

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review

Please note: This request may be denied unless all required information is received. For urgent or expedited requests please call 1-800-711-4555. This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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