BONE FORMATION STIMULATING AGENTS PRIOR AUTHORIZATION REQUEST FORM

OptumRx
P.O. Box 25184
Santa Ana, CA, 92799
Phone: (800) 310-6826 Fax: (866) 577-6384

Optum Rx®

United Healthcare Community Plan

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

Note: This form must be completed by the prescribing provider.

****All sections must be completed or the request will be returned****

Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Prescriber's Signature
Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐	Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐
Check box if requesting retro-active PA ☐	Date(s) of service requested for retro-active eligibility (if applicable):

Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).

Requested Medication and Strength	Dosage Regimen	Treatment Duration

PA Requirements for ALL Agents:

Member has a diagnosis of osteoporosis ☐ Yes ☐ No

Member is 18 years of age or older ☐ Yes ☐ No

Select ONE of the following:

☐ Member has previously tried and failed bisphosphonate therapy
Drug/dose/date(s) of use:_____

☐ Member has specific medical justification against use of bisphosphonate therapy
Please explain:_____

☐ Member has been determined to be a high-risk patient as demonstrated by the World Health Organization (WHO) Fracture Risk Assessment Model

Request is for renewal of therapy ☐ Yes ☐ No

If **yes**, provide date range or number of months member has received therapy:

_____

Bonsity, Forteo, teriparatide (authorized generic Bonsity), teriparatide (authorized generic and generic Forteo), and Tymlos

Will the total length of therapy exceed 2 years? ☐ Yes ☐ No

If **yes**, provide medical justification for continued use beyond two years.

_____

Evenity

Will the total length of therapy exceed 1 year? ☐ Yes ☐ No

If **yes**, provide medical justification for continued use beyond one year.

_____

PA Requirements for FORTEO:

Provider attests that member has none of the following conditions and has not undergone prior radiation therapy: ☐ Yes ☐ No

- Bone metastases or skeletal malignancies
- Increased baseline risk for osteosarcoma
- Metabolic bone disease other than osteoporosis
- Paget's disease of bone
- Pre-existing hypercalcemia (Ca++>12mg/dL)

If **no**, please specify if member has undergone prior radiation therapy and/or has any of the above conditions and provide medical justification for requested therapy: _____

_____

_____

PA Requirements for EVENITY:

Provider attests that member has none of the following conditions: ☐ Yes ☐ No

- Myocardial infarction or stroke within the previous year
- Osteonecrosis of the jaw
- Pre-existing hypocalcemia

If **no**, please specify if member has any of the above conditions and provide medical justification for requested therapy: _____

_____

_____

Member has experienced menopause and is currently post-menopausal ☐ Yes ☐ No

Member has tried and failed brand Forteo ☐ Yes ☐ No

Dates of use:_____

If **no,** provide medical justification for use over brand Forteo:

_____

_____

PA Requirements for BONSITY, teriparatide (authorized generic BONSITY), teriparatide (authorized generic and generic FORTEO):

Provider attests that member has none of the following conditions AND has not undergone prior radiation therapy: ☐ Yes ☐ No

- Bone metastases or skeletal malignancies
- Increased baseline risk for osteosarcoma
- Metabolic bone disease other than osteoporosis
- Paget's disease of bone
- Pre-existing hypercalcemia (Ca++>12mg/dL)

If **no**, please specify if member has undergone prior radiation therapy and/or has any of the above conditions and provide medical justification for requested therapy:

_____

_____

Member has tried and failed brand Forteo ☐ Yes ☐ No

Dates of use:_____

If **no,** provide medical justification for use over brand Forteo:

_____

_____

PA Requirements for TYMLOS:

Provider attests that member has none of the following conditions AND has not undergone prior radiation therapy: ☐ Yes ☐ No

- Bone metastases or skeletal malignancies
- Increased baseline risk for osteosarcoma
- Metabolic bone disease other than osteoporosis
- Paget's disease of bone
- Pre-existing hypercalcemia (Ca++>12mg/dL)

If **no**, please specify if member has undergone prior radiation therapy and/or has any of the above conditions and provide medical justification for requested therapy:

_____

_____

Member has tried and failed brand Forteo ☐ Yes ☐ No

Dates of use:_____

If **no,** provide medical justification for use over brand Forteo:

_____

_____