



15 Earhart Drive, Suite 101, Amherst, NY 14221

FORTEO & TYMLOS AUTHORIZATION AND RE- AUTHORIZATION REQUEST

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name:			Today's Date:			Date Needed:		
Date of birth:		Sex:	Weight:		Prescriber:		Specialty:	
Home Phone Number: () ()				Phone Number: () ()		Fax Number: () ()		
Home Address:			City:	State:	Zip:	Address:		City: State: Zip:
Member's Insurance ID:				Office Phone :		Office Fax Number:		
Allergies:				Office Contact:				

DRUG SELECTION:

New Authorization Re-authorization Request

Tymlos **Forteo**

Dose: _____ Frequency: _____

Will medication be self-injected? Yes No

STATEMENT OF MEDICAL NECESSITY:

Primary Diagnosis: _____

ICD10 Code: _____

Prior Treatments: _____

Current Treatment: _____

Has patient tried and failed to tolerate or respond to (or have a contraindication to) treatment with preferred formulary medication? (*bisphosphates, RANK-Ligand inhibitors, Estrogen agonist/antagonist, calcitonin*) Yes No

Female patient post-menopausal? Yes No

Does patient have any of the following?

- Paget's disease of the bone? Yes No
- Open epiphyses Yes No
- Pre-existing hypercalcemia Yes No
- Bone metastases or a history of skeletal malignancies? Yes No
- Prior radiation therapy involving skeleton? Yes No
- Hereditary disorders predisposing to osteosarcoma Yes No

Will patient receive concurrent Vitamin D and calcium supplements? Yes No

Patient has a history of osteoporotic fracture? Yes No

OR at least two of the following:

- History of frequent falls
- Bone density t-score more than 2.5 standard deviations below the mean
If yes: T-Score _____ Date _____
- Limited movement, such as using a wheelchair
- Medical conditions likely to cause bone loss or increase the risk of fracture
If yes please list _____
- Concurrent use of medications that may cause bone loss
If yes please list _____
- Concurrent use of medications that increase the risk of falls
If yes please list _____