Forteo

HMSACOM - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____ft _____inches

Indicate where the drug is being dispensed:

❑ Office ❑ Outpatient Hospital ❑ Ambulatory Surgical ❑ Inpatient Hospital
❑ Off Campus Outpatient Hospital ❑ Urgent Care ❑ Emergency Room ❑ Birthing Center
❑ Military Facility ❑ Skilled Nursing Facility ❑ Nursing Facility ❑ Hospice
❑ Inpatient Psychiatric ❑ Psychiatric Residential Treatment ❑ End Stage Renal Facility
❑ Psychiatric Facility ❑ Pharmacy ❑ Other

Indicate where the drug is being administered:

❑ Ambulatory surgical ❑ Home ❑ Inpatient Hospital
❑ Office ❑ Outpatient Hospital ❑ Pharmacy

What is the ICD-10 code? _____

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

 Forteo HMSACOM – 03/2024.

Criteria Questions:

1. Is the request for continuation of therapy?

❒ Yes, *Continue to #2*

❒ No, *Continue to #10*

2. Was the requested product previously authorized by HMSA/CVS for this member?

❒ Yes, *Continue to #3*

❒ No, *Continue to #10*

❒ Unknown, *Continue to #10*

3. How many months of cumulative parathyroid hormone analog therapy has the patient received in their lifetime? _____ months

❒ Less than 24 months, *Continue to #10*

❒ 24 months or greater, *Continue to #4*

4. Has the patient remained at or returned to having a high risk for fracture?

❒ Yes, *No Further Questions*

❒ No, *No Further Questions*

INITIAL THERAPY

10. What is the indication for the requested product?

❒ Treatment of osteoporosis in men or postmenopausal women, *Continue to #100*

❒ Treatment of glucocorticoid-induced osteoporosis, *Continue to #200*

❒ Other, *No Further Questions*

OSTEOPOROSIS IN MEN AND POSTMENOPAUSAL WOMEN

100. Does the member have a DEXA score of -3.0 or less? ***ACTION REQUIRED: If yes, a copy of DEXA scan results must be submitted***

❒ Yes, *Continue to #300*

❒ No, *Continue to #101*

101. Does the member have a history of greater than 2 vertebral fragility fractures? ***ACTION REQUIRED: If yes, imaging studies supporting fracture must be submitted***

❒ Yes, *Continue to #300*

❒ No, *Continue to #102*

102. Does the member have two moderate vertebral fragility fractures or reduction in vertebral body height of 26-40%? ***ACTION REQUIRED: If yes, imaging studies supporting fracture or reduction in vertebral body height must be submitted***

❒ Yes, *Continue to #300*

❒ No, *Continue to #103*

103. Does the member have one severe vertebral fragility fracture or reduction in vertebral body height of greater than 40%? ***ACTION REQUIRED: If yes, imaging studies supporting fracture must be submitted***

❒ Yes, *Continue to #300*

❒ No, *Continue to #104*

104. Is the member's pre-treatment bone mass T-score less than or equal to -2.5? ***ACTION REQUIRED: If yes, a copy of DEXA scan results must be submitted***

❒ Yes, *Continue to #105*

❒ No, *Continue to #108*

105. Does the member have a history of any vertebral or radial fracture? ***ACTION REQUIRED: If yes, imaging studies supporting fracture must be submitted***

❒ Yes, *Continue to #106*

❒ No, *Continue to #108*

106. Has the member experienced a documented inadequate response or intolerable adverse event to at least a 1-year trial of an oral or injectable bisphosphonate? ***ACTION REQUIRED: If yes, supporting documentation must be submitted***

❒ Yes, *Continue to #300*

❒ No, *Continue to #107*

107. Does the member have a clinical reason to avoid treatment with an oral or injectable bisphosphonate? ***ACTION REQUIRED: If yes, supporting documentation must be submitted***

❒ Yes, *Continue to #300*

❒ No, *Continue to #108*

108. Has the member experienced a documented inadequate response or intolerable adverse event to at least a 1-year trial of an oral or injectable bisphosphonate? ***ACTION REQUIRED: If yes, supporting documentation must be submitted***

❒ Yes, *Continue to #110*

❒ No, *Continue to #109*

109. Does the member have a clinical reason to avoid treatment with an oral or injectable bisphosphonate? ***ACTION REQUIRED: If yes, supporting documentation must be submitted***

❒ Yes, *Continue to #110*

❒ No, *Continue to #110*

110. Has the member failed prior treatment with or is unable to tolerate ALL previous injectable osteoporosis therapy (e.g., Prolia, Tymlos, Evenity) for which they are eligible? ***ACTION REQUIRED: If yes, supporting documentation must be submitted***

❒ Yes, *Continue to #300*

❒ No, *Continue to #300*

GLUCOCORTICOID-INDUCED OSTEOPOROSIS

200. Is the member currently receiving, or will the member be initiating glucocorticoid therapy at a dose greater than or equal to 2.5 mg per day of prednisone or its equivalent for at least 3 months? ***ACTION REQUIRED: If yes, documentation supporting the glucocorticoid dose and duration of therapy must be submitted***

❒ Yes, *Continue to #201*

❒ No, *Continue to #201*

201. Has the member experienced an inadequate response, intolerance or is there a clinical reason to avoid at least a 1-year trial of an oral or injectable bisphosphonate? ***ACTION REQUIRED: If yes, supporting documentation must be submitted***

❒ Yes, *Continue to #202*

❒ No, *Continue to #202*

202. Does the member have a history of fragility fracture? ***ACTION REQUIRED: Imaging studies supporting fracture must be submitted***

❒ Yes, *Continue to #300*

❒ No, *Continue to #203*

203. What is the pre-treatment bone mass T score at the femoral neck, total hip, or lumbar spine as measured by DEXA scan? ***ACTION REQUIRED: A copy of DEXA scan results must be submitted***

❒ T score less than or equal to −2.5, *Continue to #300*

❒ T score between −1.0 and −2.5, *Continue to #204*

❒ T score greater than or equal to −1.0, *No Further Questions*

204. Does the member have a high pre-treatment FRAX fracture probability? ***ACTION REQUIRED: If yes, supporting documentation must be submitted***

❒ Yes, *Continue to #300*

❒ No, *Continue to #300*

APPROVAL DURATION

300. How many months of treatment with the requested product has the member received in his/her lifetime?

_____ months

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512