# Tymlos

## 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**

**Criteria Questions:**

1. What is the indication for Tymlos?

❒ Treatment of postmenopausal osteoporosis, *Continue to #100*

❒ Osteoporosis in a man, *Continue to #120*

❒ Other, *No Further Questions*

*POSTMENOPAUSAL OSTEOPOROSIS*

100. Does the member have a DEXA score of -3.0 or less? 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? 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%? 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%? 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? 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? 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? 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? If yes, supporting documentation must be submitted

❒ Yes, *Continue to #300*

❒ No, *Continue to #300*

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? 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? 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 previous injectable osteoporosis therapy (e.g., Prolia, Evenity) for which they are eligible? If yes, supporting documentation must be submitted

❒ Yes, *Continue to #300*

❒ No, *Continue to #300*

*Osteoporosis in a man*

120. 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? If yes, supporting documentation must be submitted

❒ Yes, *Continue to #122*

❒ No, *Continue to #121*

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

❒ Yes, *Continue to #122*

❒ No, *Continue to #122*

122. Does the member have a history of vertebral or hip fracture? If yes, supporting documentation must be submitted

❒ Yes, *Continue to #300*

❒ No, *Continue to #123*

123. What is the patient's pre-treatment T-score? ***Action Required***: Attach supporting chart note(s) or medical record

❒ -2.5 or below (e.g., -2.6, -2.7, -3), *Continue to #300*

❒ Between -2.5 and -1 (e.g., -2.4, -2.3, -2), *Continue to #124*

❒ -1 or above (e.g., -0.9, -0.8, -0.5), *No Further Questions*

❒ Unknown, *No Further Questions*

124. What is the patient's pre-treatment FRAX score for any major fracture?

❒ Greater than or equal to 20%, *Continue to #300*

❒ Less than 20%, *Continue to #125*

❒ Unknown, *Continue to #125*

125. What is the patient's pre-treatment FRAX score for hip fracture?

_____%, *Continue to #300*

*APPROVAL DURATION*

300. How many months of treatment with Tymlos has the member received in his/her lifetime?
_____months, *No Further Questions*

***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**