CareSource Rxinnovations

INDIANA HEALTH COVERAGE PROGRAMS (IHCP) PHARMACY BENEFIT
BONE FORMATION STIMULATING AGENTS PRIOR AUTHORIZATION REQUEST FORM

CareSource Pharmacy Prior Authorization Form
P.O. Box 8738
Dayton, OH 45401-8738
Fax: (866) 930-0019

Today's Date ☐☐ / ☐☐ / ☐☐☐☐

Non-Urgent: ☐ Urgent: ☐

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

****All sections must be completed by the prescribing provider. Incomplete requests will be returned.****

Patient's CareSource ID # ☐☐☐☐☐☐☐☐☐☐☐☐	Date of Birth ☐☐ / ☐☐ / ☐☐☐☐
Patient's Name	Prescriber's Name
Prescriber's IN License # ☐☐☐☐☐☐☐☐	Specialty
Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐	Office Contact
Prescriber Fax ☐☐☐ - ☐☐☐ - ☐☐☐☐	Prescriber Phone ☐☐☐ - ☐☐☐ - ☐☐☐☐
Prescriber Address	Date(s) of Service: _____ Start Date: _____
Diagnosis	Diagnosis Code

Requested Medication and Strength	Directions for Use	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 rationale 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:

_____

Forteo and Tymlos

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

If yes, provide medication rationale for continued use beyond two years.

_____

Evenity

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

If yes, provide medication rationale 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 rationale to justify requested therapy:

_____

_____

_____

Prescriber Signature: _____ **Date:** _____

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 rationale to justify requested therapy:

_____

_____

_____

Prescriber Signature: _____ **Date:** _____

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 TERIPARATIDE:

Provider attests that member has none of the following conditions or has 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 rationale to justify requested therapy:

_____
_____
_____

Prescriber Signature: _____ **Date:** _____

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 or has 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 rationale to justify requested therapy:

_____
_____
_____

Prescriber Signature: _____ **Date:** _____

Member has tried and failed brand Forteo? □ Yes □ No

Dates of use:_____

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

_____
_____
_____