COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

FORTEO® OR TYMLOS™

If the following information is not complete, correct, or legible, the SA process can be delayed.

Please use one form per member.

MEMBER INFORMATION

Last Name:

First Name:

Medicaid ID Number:

Date of Birth: ___ – ___ – ____

Gender: ☐ **Male** ☐ **Female**

Weight in Kilograms: _____

PRESCRIBER INFORMATION

Last Name:

First Name:

NPI Number:

Phone Number: ___ – ___ – ____

Fax Number: ___ – ___ – ____

DRUG INFORMATION

Drug Name/Form: _____

Strength: _____

Dosing Frequency: _____

Length of Therapy: _____

Quantity per Day: _____

(Form continued on next page.)

 Revised: 10/28/2022 | Effective: 07/01/2021

Member's Last Name:

Member's First Name:

DIAGNOSIS AND MEDICAL INFORMATION

1. Is the member 18 or older?

   ☐ Yes ☐ No

2. Does the member have a confirmed diagnosis of osteoporosis?

   ☐ Yes ☐ No

3. Has the member experienced a therapeutic failure or inadequate response to at least two bisphosphonates?

   ☐ Yes ☐ No

   If NO, is the member unable to receive or have a contraindication to a bisphosphonate?

   ☐ Yes ☐ No

   List details: _____

4. Is the member a male requiring increased bone mass with primary or hypogonadal osteoporosis?

   ☐ Yes ☐ No

5. Is the member at a high risk for fractures?

   ☐ Yes ☐ No

6. Will the member be taking calcium and vitamin D supplementation if dietary intake is inadequate?

   ☐ Yes ☐ No

7. Does the member have a documented Hip DXA (femoral neck or total hip) or lumbar spine T-score -2.5 (standard deviations) or below?

   ☐ Yes ☐ No

8. Does the member have Bone Mineral Density (BMD) of -3 or worse?

   ☐ Yes ☐ No

9. Is the member a postmenopausal woman with history of non-traumatic fracture(s)?

   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

10. Is the member a postmenopausal woman with two or more of the following clinical risk factors:
    - ☐ Family history of non-traumatic fracture(s)
    - ☐ DXA BMD T-score ≤-2.5 at any site
    - ☐ More than 2 alcohol beverages per day
    - ☐ Glucocorticoid use* (≥ 6 months of use at 7.5 dose of prednisolone equivalent)
    - ☐ History of non-traumatic fracture(s)
    - ☐ Rheumatoid Arthritis
    - ☐ Current smoker
11. Member is not at increased risk for osteosarcoma (e.g., Paget's disease of bone, bone metastases or skeletal malignancies, etc.)?
    - ☐ Yes ☐ No
12. Member has not received therapy with parathyroid hormone analogs (e.g., Forteo) in excess of 24 months in total?
    - ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the SA process.
Submission of documentation does NOT guarantee coverage by the Department of Medical Assistance Services.

The completed form may be: **FAXED TO 800-932-6651**, phoned to 800-932-6648, or mailed to:
Magellan Medicaid Administration / ATTN: MAP
11013 W. Broad Street, Glen Allen, VA 23060