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CardinalCare
Virginia's Medicaid Program

COMMONWEALTH OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Service Authorization (SA) Form

FORTEO®, teriparatide 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: _____

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.)

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 assigned male at birth 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 postmenopausal 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 post-menopausal 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:
Prime Therapeutics Management LLC
Attn: GV – 4201
P.O. Box 64811
St. Paul, MN 55164-0811