

Nevada Medicaid - Molina Healthcare

Tymlos® (abaloparatide) Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.

Member Information(required)			Provider Information (required)			
Member Name:			Provider Name:			
Molina ID#:			NPI#:	Specialty:		
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
:	State:	Zip:	Office Street Address:			
hone:			City:	Stat	e:	Zip:
Medication Information (required)						
Medication Name:			Strength:	Dosage Form:		
☐ Check if requesting brand ☐ Check if request is for initial therapy ☐ Check if request is for recertification of therapy			Directions for Use:			
Clinical Information (required)						
Select the diagnosis below:						
☐ Diagnosis of postmenopausal osteoporosis or osteopenia						
Other diagnosis:	ICD-10 Code(s):					
Drug-Specific Information (required)						
☐ The recipient's Bone Mineral Density (BMD) T-score is -2.5 or lower in the lumbar spine, femoral neck, total hip or radius (one-third radius site).						
☐ The recipient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site).						
☐ The recipient has documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis or distal forearm.						
The recipient has documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia® [denosumab]).						
☐ The recipient has a FRAX 10-year probability of a major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions.						
☐ The recipient has a FRAX 10-year probability of a hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions.						
The recipient's treatment duration of parathyroid hormones has not exceeded a total of 24 months during their lifetime.						
	na ID#: e of Birth: et Address: : ne: lication Name: heck if requesting brand heck if request is for initial heck if request is for receivent the diagnosis below Diagnosis of postmenopa Other diagnosis: The recipient has a BMD The recipient has docum radius site). The recipient has docum The recipient has docum risedronate, zoledronic a The recipient has a FRAX threshold in other countr The recipient has a FRAX countries or regions.	na ID#: e of Birth: et Address: : State: heck if requesting brand heck if request is for initial therapy heck if request is for recertification of the heck if requesting brand heck if request is for initial therapy heck if request is for recertification of the heck if requesting brand heck if request is for initial therapy heck if request is for recertification of the heck if request is for initial therapy heck if request is for initial therapy heck if request is for initial therapy heck if request is for recertification of the heck if request is for initial therapy heck if request is	In a ID#: e of Birth: et Address: State: State: Medication Infection Infection Name: State: Clinical Infect the diagnosis below: Diagnosis of postmenopausal osteoporosis or osteopenia Other diagnosis: Drug-Specific The recipient's Bone Mineral Density (BMD) T-score is -2.5 or radius site). The recipient has a BMD T-score between -1.0 and -2.5 in the recipient has documented history of low-trauma fracture The recipient has documented trial and failure, contraindicat risedronate, zoledronic acid, Prolia® [denosumab]). The recipient has a FRAX 10-year probability of a major oste threshold in other countries or regions. The recipient has a FRAX 10-year probability of a hip fracture countries or regions.	na ID#: of Birth: of Birth: of Birth: office Phone: et Address: State: State: Diffice Street Address: City: Medication Information (required) Strength: City: Medication Information (required) Strength: Clinical Information (required) Clinical Information (required) Diagnosis of postmenopausal osteoporosis or osteopenia Other diagnosis: Drug-Specific Information (required) The recipient's Bone Mineral Density (BMD) T-score is -2.5 or lower in the lumbar spine, femo radius site). The recipient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoradius site). The recipient has documented history of low-trauma fracture of the hip, spine, proximal humer The recipient has documented trial and failure, contraindication, or intolerance to one anti-rescrisedronate, zoledronic acid, Prolia® [denosumab]). The recipient has a FRAX 10-year probability of a major osteoporotic fracture at 20% or more threshold in other countries or regions.	na ID#: of Birth: of Birth: of Birth: office Phone: office Fax: city: City: State: Idea of Birth: office Fax: City: State: State: Idea of Birth: office Fax: City: State: Idea of Birth: office Fax: City: State: Idea of Birth: Office Phone: City: State: Idea of Birth: Office Phone: Office Fax: City: State: Idea of Strength: Idea of Information (required) Info	na ID#: na ID#: na ID#: of Birth: of Birth: office Phone: et Address: City: State: City: State: Medication Information (required) lication Name: heck if requesting brand heck if request is for initial therapy theck if request is for recertification of therapy Clinical Information (required) Birections for Use: Clinical Information (required) Clinical Information (required) Directions for Use: Directions for Use: Clinical Information (required) The recipient has a BMD T-score is -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius site). The recipient has a BMD T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius site). The recipient has documented history of low-trauma fracture of the hip, spine, proximal humerus, pelvis or distal for the recipient has documented trial and failure, contraindication, or intolerance to one anti-resorptive treatment (e. risedronate, zoledronic acid, Prolia® [denosumab]). The recipient has a FRAX 10-year probability of a hip fracture at 3% or more in the U.S., or the countries or regions.

Attach any additional comments, diagnoses, symptoms, medications tried or failed, or other information the physician feels is important to this review

<u>Please note</u>: This request may be denied unless all required information is received. For urgent or expedited requests please call (833) 685-2103. This form may be used for non-urgent requests and faxed to (844) 259-1689.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of Molina Healthcare. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately.