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

**MDwise**
**Fax to: (858) 790-7100**
**c/o MedImpact Healthcare Systems, Inc.**
**Attn: Prior Authorization Department**
**10181 Scripps Gateway Court, San Diego, CA 92131**
**Phone: (800) 788-2949**

MDwise
A McLaren Company

Today's Date
☐☐ / ☐☐ / ☐☐☐☐

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

****All sections must be completed or the request will be returned****

| | |
|---|---|
| Patient's Medicaid # ☐☐☐☐☐☐☐☐☐☐☐☐ | Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ |
| Patient's Name | Prescriber's Name |
| Prescriber's IN License # ☐☐☐☐☐☐☐☐ | Specialty |
| Prescriber's NPI # ☐☐☐☐☐☐☐☐☐☐ | Prescriber's Signature |
| Return Fax # ☐☐☐ - ☐☐☐ - ☐☐☐☐ | Return Phone # ☐☐☐ - ☐☐☐ - ☐☐☐☐ |
| Check box if requesting retro-active PA ☐ | Date(s) of service requested for retro-active eligibility (if applicable): |

*Note: Submit PA requests for retroactive claims (dates of service prior to eligibility determination, but within established eligibility timelines) with dates of service prior to 30 calendar days of submission separately from current PA requests (dates of service 30 calendar days or less and going forward).*

| Requested Medication and Strength | Dosage Regimen | 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:** _____

## 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:** _____

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:** _____

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:** _____

Member has tried and failed brand Forteo ☐ Yes ☐ No

Dates of use:_____

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

_____

_____