pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

BONE DENSITY REGULATORS PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines **Bone Density Regulators** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For treatment of an OSTEOPOROSIS-RELATED condition:
   - ☐Has results of a recent bone mineral density test → Document T-score: _____ Date of test: _____
   - ☐Was evaluated for other possible causes of osteoporosis and has results of the following lab tests:
     - ☐CBC ☐Phosphorous ☐Total protein ☐Thyroid stimulating hormone (TSH)
     - ☐Vitamin D ☐Creatinine ☐Urinary calcium excretion ☐Intact parathyroid hormone (PTH)
     - ☐Ionized calcium ☐Albumin ☐Testosterone (if male) ☐Liver enzymes (specifically alkaline phosphatase)

2. For an ANABOLIC AGENT (EVENITY, FORTEO / TERIPARATIDE, TYMLOS):
   - ☐Has a history of fragility fracture
   - ☐Has a history of multiple vertebral fractures
   - ☐Has a history of trial and failure of or a contraindication or an intolerance to bisphosphonates
   - ☐Request will not exceed the cumulative treatment duration recommended in the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature
   - ☐For Forteo/teriparatide and Tymlos – check all that apply to the beneficiary:
     - ☐Paget's disease of the bone ☐Metabolic bone disease other than osteoporosis
     - ☐Bone metastases ☐Hypercalcemic disorder(s)
     - ☐History of skeletal malignancies ☐Unexplained elevations of alkaline phosphatase
     - ☐Open epiphyses ☐Prior external beam or implant radiation therapy involving the skeleton
   - ☐For Evenity – check all that apply to the beneficiary:
     - ☐History of myocardial infarction

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☐ History of stroke

☐ For Evenity or Tymlos:
- ☐ Has a contraindication or an intolerance to teriparatide

☐ For Forteo:
- ☐ Has a contraindication or an intolerance to teriparatide that would not be expected to occur with Forteo

3. For EVISTA (raloxifene):

☐ Check all that apply to the beneficiary:
- ☐ History of venous thromboembolic events (including deep vein thrombosis, pulmonary embolism, and retinal vein thrombosis)
- ☐ History of breast cancer

☐ Has one or more risk factors for stroke:
- ☐ History of stroke or TIA ☐ Hypertension ☐ other: _____
- ☐ Atrial fibrillation ☐ Cigarette smoker

☐ If beneficiary has one or more risk factors for stroke, was counseled by the prescriber about the increased risk of death due to stroke

☐ Is a post-menopausal or post-oophorectomy female

☐ Has a 10-year probability of hip fracture ≥ 3% based on the US-adapted WHO algorithm

☐ Has a 10-yr probability of major fracture related to osteoporosis ≥ 20% based on the US-adapted WHO algorithm

☐ Has a history of fragility fracture of the proximal humerus, pelvis, or distal forearm

☐ Has a history of low-trauma spine or hip fracture

☐ Is at high risk for invasive breast cancer defined by at least one of the following:
- ☐ Prior biopsy with lobular carcinoma in situ (LCIS) or atypical hyperplasia
- ☐ One or more first-degree relatives with breast cancer
- ☐ A 5-year predicted risk of breast cancer ≥ 1.66% (based on the modified Gail model)

☐ Has a history of trial and failure of or a contraindication or an intolerance to oral bisphosphonates

4. For XGEVA (denosumab):

☐ Is being treated for a diagnosis that is included in the FDA-approved package labeling OR is supported by peer-reviewed medical literature or nationally recognized medical compendia

5. For ALL OTHER NON-PREFERRED Bone Density Regulators:

☐ Has a 10-year probability of hip fracture ≥ 3% based on the US-adapted WHO algorithm

☐ Has a 10-year probability of major fracture related to osteoporosis ≥ 20% based on the US-adapted WHO algorithm

☐ Has a history of fragility fracture of the proximal humerus, pelvis, or distal forearm

☐ Has a history of low-trauma spine or hip fracture

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Bone Density Regulators approved or medically accepted for the treatment of the beneficiary's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐ For a non-preferred PARENTERAL bisphosphonate:
- ☐ Has a contraindication or an intolerance to oral bisphosphonates

RENEWAL requests

1. For ALL renewal requests:

☐ The beneficiary's condition has stabilized since starting the requested medication

☐ The beneficiary continues to benefit from the requested medication

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: