Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Tymlos (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Tymlos (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Tymlos (abaloparatide)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has the member received a total of 24 months of therapy with Forteo and Tymlos? Y N

   [If yes, then no further questions.]

2. Is Tymlos requested for the treatment of postmenopausal osteoporosis? Y N

   [If no, then no further questions.]

3. Does the member have a low bone density less than 2.5 SD (standard deviations) below normal (T-score less than -2.5) OR does the member have a fragility fracture at the hip, spine, wrist, arm, rib, or pelvis? Y N

If yes, submit records or document T-score and date: _____

[If no, then no further questions.]

4. Does the member meet ONE of the following? A) Reduction in bone mineral density (BMD) per recent DEXA scan after at least 2 years of compliant therapy with an oral or intravenous (IV) bisphosphonate, B) New fracture while taking an oral or IV bisphosphonate, or C) Contraindication or SEVERE intolerance to oral bisphosphonates (e.g., current upper GI symptoms, inability to swallow, or inability to remain in an upright position after oral bisphosphonate administration for the required length of time) Y N

   If yes, submit records or provide details here:
   _____

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature **Date**