aetna®

Tymlos™ (abaloparatide) Medication Precertification Request

(All fields must be completed and legible for Precertification Review.)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____
Group #: _____
Insured: _____

Does patient have other coverage? ☐ Yes ☐ No
If yes, provide ID#: _____ Carrier Name: _____
Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:	Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.				
Address:	City:	State:	ZIP:		
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:	Office Contact Name:	Phone:			

Specialty *(Check one):* ☐ **GYN** ☐ **Orthopedic** ☐ **Primary Provider** ☐ **Other:** _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *Patient Selected choice*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Tymlos: Dose: _____ **Frequency:** _____

F. DIAGNOSIS INFORMATION – Please indicate primary ICD Code and specify any other where applicable.

Primary ICD Code: _____ Secondary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION – Required clinical information must be completed in its entirety for all precertification requests.

For All Requests (clinical documentation required)

Please provide the patient's Bone Mineral Density (BMD) score and date obtained: T-score: _____ Date: ____/____/____

☐ Yes ☐ No Does the patient have clinical evidence of uncorrected preexisting hypocalcemia?
☐ Yes ☐ No Is the patient at high risk for fractures?
☐ Yes ☐ No Has the cumulative use of Tymlos (abaloparatide) and parathyroid hormone analogs (e.g., teriparatide) exceeded 2 years duration?

For initiation requests:

Post-menopausal osteoporosis

☐ Yes ☐ No Has the patient had an osteoporotic fracture?
☐ Yes ☐ No Does the patient have multiple risk factors for fractures?
→ Please select all that apply: ☐ anorexia nervosa ☐ alcohol intake of 4 or more units a day ☐ corticosteroid therapy ☐ smoking
☐ Cushing's syndrome ☐ failed previous osteoporosis therapy ☐ high risk for falls ☐ history of osteoporosis fractures
☐ increasing age ☐ intolerant to previous osteoporosis therapy ☐ low body mass ☐ parental history of hip fracture
☐ rheumatoid arthritis ☐ other: please explain: _____

☐ Yes ☐ No Is there clinical evidence that a trial of two bisphosphonates was ineffective?
→ ☐ Yes ☐ No Is there clinical evidence that a trial of at least one bisphosphonate and one selective estrogen receptor modulator (SERM)?
→ Please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____
→ Please select which of the following bisphosphonates and/or SERM's the patient tried

Select all that apply: ☐ Actonel or Actonel with Calcium (risedronate) ☐ Atelvia (risedronate) ☐ Boniva (ibandronate)
☐ Didronel (etidronate ☐ Fosamax or Fosamax plus D (alendronate) ☐ Skelid (tiludronate)
☐ Zometa/Reclast (zoledronic acid) ☐ Fareston (toremifene) ☐ Tamoxifen (nolvadex)
☐ Evista (raloxifene) ☐ Other: Please identify: _____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

Bisphosphonate #1 Date range: _____/ _____/_____ to _____/_____/____

Bisphosphonate #2 OR SERM Date range: _____/ _____/_____ to _____/_____/____

☐ Yes ☐ No Is there documented evidence that the patient has an intolerance to bisphosphonates and/or SERMs?

→ ***Select all that apply:*** **Bisphosphonates**: ☐ Persistent upper GI disturbance ☐ Severe musculoskeletal pain ☐ Hypocalcemia
☐ Other: please explain: _____

SERM: ☐ Flu Syndrome ☐ Hot flashes ☐ Nausea/vomiting or diarrhea ☐ Arthralgia ☐ Rhinitis
☐ Other: please specify: _____

☐ Yes ☐ No Is there documented evidence that the patient has a contraindication to bisphosphonates and/or SERMs?

→ ***Select all that apply:*** **Bisphosphonates**: ☐ Renal Impairment ☐ Hypersensitivity to bisphosphonates or components
☐ Other: please identify: _____

SERM: ☐ Active or history of venous thromboembolism (e.g. DVT, PE, RVT) ☐ Hypersensitivity
☐ Hx. of CVA or TIA ☐ Other: please identify: _____

For continuation requests:

☐ Yes ☐ No Does the patient have a hypersensitivity to Tymlos (abaloparatide)?

→ Please indicate which of the following reactions the patient had:
☐ anaphylaxis ☐ dyspnea ☐ facial and upper airway edema ☐ hypotension ☐ pruritus ☐ rash ☐ uticaria
☐ other: _____

Please indicate what type of response the patient has experienced on therapy:

Select appropriate response: ☐ No response ☐ Minimal response ☐ Adequate response ☐ Significant improvement

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.