Prior Authorization Form

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested authorization(s). Attach additional sheets to this form if necessary.

Please fax the completed PA form and any additional informational sheets to Nirvanahealth at the following fax number: +1(866) 871-8565

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
Health Plan Name:		Prescriber Address:	
Patient Insurance Id:			
Patient Date of Birth:		Prescriber Phone:	( )
Patient Phone:		Prescriber Fax:	( )
		Prescriber Specialty:	
		Prescriber DEA:	
		Prescriber NPI:	

Medication & Medical Information	
Requested Drug(s) & Strength(s):	[ ] teriparatide 20 mcg/dose (620 mcg/2.48 mL) subcutaneous pen injector
Requested Daily Quantity Limit – Amount:	
Requested Daily Quantity Limit – Days:	
Requested Quantity Limit Over Time – Amount:	
Requested Quantity Limit Over Time – Days:	
Requested Quantity Per Rx – Amount:	
Expected Length of Therapy:	
Directions:	
Diagnosis and Diagnosis Codes (ICD-10 Standard Codes):	
List drugs used previously to treat the same condition:	
Additional clinical information or history. Please include any relevant test results and/or medical record notes:	

Questionnaire

Q1: I, as the provider or designated representative of the provider, certify and attest that the information provided is complete and accurate and that, upon request, I shall provide any information to RxAdvance that RxAdvance determines is reasonably necessary to verify my responses. (Check only one that apply)

[ ] Yes

[ ] No

Q2: Is the member currently treated with this medication? (Check only one that apply)

[ ] Yes (please list start date of therapy (month/day/year)) _____

(*Required)

[ ] No

Q3: What is the member's diagnosis? (Check only one that apply)

[ ] Postmenopausal osteoporosis or osteopenia

[ ] Men with primary or hypogonadal osteoporosis or osteopenia

[ ] Glucocorticoid-Induced Osteoporosis

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q4: Has the member's treatment duration with parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)] exceeded 24 months of therapy during the member's lifetime? (Check only one that apply)

[ ] Yes

[ ] No

Q5: Has the member remained at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)]? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q6: What is the member's diagnosis? (Check only one that apply)

[ ] Postmenopausal osteoporosis or osteopenia

[ ] Men with primary or hypogonadal osteoporosis or osteopenia

[ ] Glucocorticoid-Induced Osteoporosis

[ ] Other (please specify the member's diagnosis and provide clinical rationale for the request) _____(*Required)

Q7: Has the member have bone mineral density (BMD) T-score of -2.5 or lower in the lumbar spine, femoral neck, total hip, or radius (one-third radius site)? (Check only one that apply)

[ ] Yes (please specify test report of T-score) _____(*Required)

[ ] No (please provide clinical rationale for the request)

Q8: Does the member have history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm? (Check only one that apply)

[ ] Yes (please specify the test report) _____(*Required)

[ ] No

Q9: Has the member had an inadequate response, intolerance or experienced contraindication(s) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No

Q10: Does the member have bone mineral density (BMD) T-score between -1.0 and -2.5 in the lumbar spine, femoral neck, total hip, or radius (one-third radius site) ? (Check only one that apply)

[ ] Yes (please specify test report of T-score) _____(*Required)

[ ] No

Q11: Does the member have history of low-trauma fracture of the hip, spine, proximal humerus, pelvis, or distal forearm? (Check only one that apply)

[ ] Yes (please specify the test report) _____(*Required)

[ ] No

Q12: Has the member had an inadequate response, intolerance or experienced contraindication(s) to one osteoporosis treatment (e.g., alendronate, risedronate, zoledronic acid, Prolia [denosumab])? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q13: Select one if the member has the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: (Check only one that apply)

[ ] Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions _____(*Required)

[ ] Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q14: Does the member have history of prednisone or its equivalent at a dose greater than or equal to 5mg/day for greater than or equal to 3 months? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q15: Does the member bone mineral density (BMD) T-score score less than or equal to -2.5 based on BMD measurements from lumbar spine, femoral neck, total hip, or radius (one-third radius site)? (Check only one that apply)

[ ] Yes (please specify test report of T-score) _____(*Required)

[ ] No

Q16: Select one if the member has the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities: (Check only one that apply)

[ ] Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions

[ ] Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions

[ ] No

Q17: Does the member have history of one of the following fractures resulting from minimal trauma: vertebral compression fracture, fracture of the hip, fracture of the distal radius, fracture of the pelvis, or fracture of the proximal humerus? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q18: Has the member had an inadequate intolerance or experienced contraindication(s) to one bisphosphonate (e.g., alendronate)? (Check only one that apply)

[ ] Yes (please specify corresponding contraindication(s) or intolerance experienced and the start and end date(s) of therapy (month/year)) _____(*Required)

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Q19: Has the member's treatment duration with parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)] exceeded 24 months of therapy during the member's lifetime? (Check only one that apply)

[ ] Yes

[ ] No

Q20: Has the member remained at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones [e.g., teriparatide, Tymlos (abaloparatide)]? (Check only one that apply)

[ ] Yes

[ ] No (please provide clinical rationale for the request) _____ (*Required)

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.	
Signature of Prescriber or Authorized Representative:	Date:
Print Authorized Representative Name:	