AETNA BETTER HEALTH® OF VIRGINIA REQUEST FORM

BONSITY®, FORTEO®, teriparatide or TYMLOS™

Fax back to: 1-855-799-2553

If the following information is not complete, correct, or legible, the PA process can be delayed. Please use one form per member.

MEMBER INFORMATION

Last Name: ______________________ **First Name:** ______________________

Medicaid ID Number: ______________________ **Date of Birth:** ______________________

Weight in Kilograms: ____________________________

PRESCRIBER INFORMATION

Last Name: ______________________ **First Name:** ______________________

NPI Number: ______________________

Phone Number: ______________________ **Fax Number:** ______________________

DRUG INFORMATION

Drug Name/Form: ______________________

Strength: ______________________

Dosing Frequency: ______________________

Length of Therapy: ______________________

Quantity per Day: ______________________

(Form continued on next page.)

Member's Last Name: ______________________ **Member's First Name:** ______________________

DIAGNOSIS AND MEDICAL INFORMATION

1. Is the member 18 or older?
   ☐ Yes ☐ No
2. Does the member have a confirmed diagnosis of osteoporosis?
   ☐ Yes ☐ No
3. Has the member experienced a therapeutic failure or inadequate response to at least two bisphosphonates?
   ☐ Yes ☐ No
   If **No**, is the member unable to receive or have a contraindication to a bisphosphonate?
   ☐ Yes ☐ No
   List details: ____
4. Is the member assigned male at birth requiring increased bone mass with primary or hypogonadal osteoporosis?
   ☐ Yes ☐ No
5. Is the member at a high risk for fractures?
   ☐ Yes ☐ No
6. Will the member be taking calcium and vitamin D supplementation if dietary intake is inadequate?
   ☐ Yes ☐ No
7. Does the member have a documented Hip DXA (femoral neck or total hip) or lumbar spine T-score -2.5 (standard deviations) or below?
   ☐ Yes ☐ No
8. Does the member have Bone Mineral Density (BMD) of -3 or worse?
   ☐ Yes ☐ No
9. Is the member postmenopausal with history of non-traumatic fracture(s)?
   ☐ Yes ☐ No

(Form continued on next page.)

Member's Last Name: ______________________ **Member's First Name:** ______________________

10. Is the member post-menopausal with two or more of the following clinical risk factors:
    - ☐ Family history of non-traumatic fracture(s)
    - ☐ DXA BMD T-score ≤ -2.5 at any site
    - ☐ More than 2 alcohol beverages per day
    - ☐ Glucocorticoid use (≥ 6 months of use at 7.5 dose of prednisolone equivalent)
    - ☐ History of non-traumatic fracture(s)
    - ☐ Rheumatoid Arthritis
    - ☐ Current smoker
11. Member is not at increased risk for osteosarcoma (e.g., Paget's disease of bone, bone metastases or skeletal malignancies, etc.)?

    ☐ Yes ☐ No
12. Member has not received therapy with parathyroid hormone analogs (e.g., Forteo) in excess of 24 months in total?

    ☐ Yes ☐ No

______________________________________ ______________________

Prescriber Signature (Required) **Date**

By signature, the physician confirms the above information is accurate and verifiable by member records.

Please include ALL requested information; Incomplete forms will delay the PA process. Submission of documentation does NOT guarantee coverage.