health information designs

Osteoporosis Agents
Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for non-preferred osteoporosis agents must meet the following criteria:

- Patient must have a diagnosis of an FDA approved indication for use
- Patient must have a current BMD T-score ≤ -2.5 OR new fracture after 6-month trials of each of the following:
  - Denosumab AND either Alendronate or Risedronate
- Patient must be at high risk of fracture, confirmed by at least one of the following:
  - History of hip or vertebral fracture
  - T-score of BMD measurements at the femoral neck or spine is ≤ -2.5 OR between −1.0 and −2.5 & a 10-year hip fracture risk ≥3% as assessed with the FRAX
  - 10-year risk of a major osteoporosis-related fracture of ≥20% as assessed with the FRAX
- Additional Criteria for Forteo and Miacalcin:
  - Patient must have a current BMD T-score ≤ -2.5 OR new fracture after 6-month trials of each of the following:
    - Evenity (Romosozumab) AND Tymlos (Abaloparatide)

Part I: TO BE COMPLETED BY PHYSICIAN

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Drug and Dosage:	**Diagnosis for this request:**		
List all failed medications:		**Start Date:**	**End Date:**

Qualifications for coverage:

Patient's BMD T-Score:	Site of BMD Measurement:
Does the patient have a history of low trauma fracture?	□ YES □NO
Has the patient had a new fracture within the last 6-months?	□ YES □NO
Does the patient have multiple risk factors for fracture?	□ YES □NO

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #