HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Bone Density Regulators

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:	Prescriber Name:	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Primary Phone:	NPI:	*PA PROMISe ID:*
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Line of Business: ☐ Medicaid ☐ CHIP	*Specialty Pharmacy (if applicable):*	
Drug Name:	**Strength:**	
Quantity:	**Refills:**	
Directions:		
Diagnosis Code:	**Diagnosis:**	

HPP's maximum approval time is 12 months but may be less depending on the drug.

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the requested medication prescribed for the treatment of a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication?

☐ Yes ☐ No

Q2. Is the prescribed dose and duration of therapy for the requested medication consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q3. Does the patient have a contraindication to the requested medication?

☐ Yes ☐ No

Q4. Is the request for an osteoporosis related condition?

☐ Yes ☐ No

Q5. Was the patient evaluated for secondary causes of osteoporosis including the following: complete blood count (CBC), vitamin D, ionized calcium, phosphorus, albumin, total protein,

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creatinine, liver enzymes (specifically alkaline phosphatase), intact parathyroid hormone (PTH), thyroid stimulating hormone (TSH), urinary calcium excretion, and testosterone (if a male)?

☐ Yes ☐ No

Q6. Is the request for an anabolic agent?

☐ Yes ☐ No

Q7. Does the patient have a T score of negative three and five tenths (-3.5) or below?

☐ Yes ☐ No

Q8. Does the patient have a T score of negative two and five tenths (-2.5) or below?

☐ Yes ☐ No

Q9. Does the patient have a history of fragility fracture?

☐ Yes ☐ No

Q10. Does the patient have a history of therapeutic failure (i.e., documented continued bone loss or fragility fracture after two (2) or more years despite treatment with a bisphosphonate), intolerance, or contraindication to bisphosphonates?

☐ Yes ☐ No

Q11. Has the patient received a cumulative treatment duration that exceeds recommendations in the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature?

☐ Yes ☐ No

Q12. Does the patient have a history of ANY of the following: For Forteo and Tymlos: A) Paget's disease, B) bone metastases, C) a history of skeletal malignancies, D) metabolic bone disease other than osteoporosis, E) hypercalcemic disorders, F) unexplained elevations of alkaline phosphatase, G) open epiphyses, or H) prior external beam or implant radiation therapy involving the skeleton; for Evenity: A) myocardial infarction?

☐ Yes ☐ No

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Q13. Is the requested medication Evenity (romosozumab) or Tymlos (abaloparatide)?

☐ Yes ☐ No

Q14. Is the requested medication teriparatide?

☐ Yes ☐ No

Q15. Is the requested medication Forteo?

☐ Yes ☐ No

Q16. Does the patient have a contraindication or intolerance to that would not be expected to occur with Forteo?

☐ Yes ☐ No

Q17. Is the requested medication Evista (raloxifene)?

☐ Yes ☐ No

Q18. Does not have a history of venous thromboembolic event or breast cancer? Yes

☐ Yes ☐ No

Q19. Is the patient a women with a risk factor for stroke (such as prior stroke or transient ischemic attack (TIA), atrial fibrillation, hypertension, or cigarette smoking)?

☐ Yes ☐ No

Q20. Has the increased risk of death due to stroke been discussed with the patient and documented by the prescriber?

☐ Yes ☐ No

Q21. Is the patient a postmenopausal woman at high risk of fracture (i.e., T-score between negative 1.0 and negative 2.5 and a history of fragility fracture of the proximal humerus, pelvis, or distal forearm; T-score between negative 1.0 and negative 2.5 at the femoral neck, total hip, or lumbar spine and a 10-year probability of a hip fracture greater than or equal to 3 percent or a 10-year probability of a major osteoporosis-related fracture greater than or equal to 20 percent

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based on the US-adapted World Health Organization (WHO) algorithm; T-score negative 2.5 or below at the femoral neck, total hip, or lumbar spine; OR history of low-trauma spine or hip fracture, regardless of bone density)?

☐ Yes ☐ No

Q22. Is the patient at high risk for invasive breast cancer as defined by one of the following: A) prior biopsy with lobular carcinoma in situ (LCIS) or atypical hyperplasia, B) one or more first degree relatives with breast cancer, or C) A 5-year predicted risk of breast cancer greater than or equal to 1.66 percent (based on the modified Gail model)?

☐ Yes ☐ No

Q23. Does the patient have a history of therapeutic failure (i.e., documented continued bone loss or fragility fracture after two (2) or more years despite treatment with a bisphosphonate), intolerance, or contraindication to bisphosphonates?

☐ Yes ☐ No

Q24. Is the requested medication Xgeva (denosumab)?

☐ Yes ☐ No

Q25. Does the patient have a high risk of fracture (i.e., T-score between negative 1.0 and negative 2.5 and a history of fragility fracture of the proximal humerus, pelvis, or distal forearm; T-score between negative 1.0 and negative 2.5 at the femoral neck, total hip, or lumbar spine and a 10-year probability of a hip fracture greater than or equal to 3 percent or a 10-year probability of a major osteoporosis-related fracture greater than or equal to 20 percent based on the USadapted World Health Organization (WHO) algorithm; T-score negative 2.5 or below at the femoral neck, total hip, or lumbar spine; OR history of low-trauma spine or hip fracture, regardless of bone density)?

☐ Yes ☐ No

Q26. Does the patient have a history of therapeutic failure (i.e., documented continued bone loss or fragility fracture after two (2) or more years despite treatment with a bisphosphonate), intolerance, or contraindication to the preferred bone density regulators approved or medically accepted for the patient's diagnosis?

☐ Yes ☐ No

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Q27. Is the request for a parenteral bisphosphonate?

☐ Yes ☐ No

Q28. Does the patient have a contraindication or intolerance to oral bisphosphonates?

☐ Yes ☐ No

Q29. For renewals: Has the patient's condition stabilized or is the patient benefitting from the requested drug?

☐ Yes ☐ No

Q30. Additional Information:

Prescriber Signature

Date

v2025