Jefferson Health Plans

MEDICAID / CHIP

PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Bone Density Regulators

Phone: 866-841-7659 **Fax back to: 866-240-3712**

Jefferson Health 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:	
Member ID Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Member Phone Number:	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:**	

Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..

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. The request is for renewal of the Bone Density Regulator that was previously approved. If YES, go to 19. If NO, go to 2.

☐ Yes ☐ No

Q2. The member meets ALL of the following:

☐ Is prescribed the Bone Density Regulator 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

☐ Is prescribed a dose and duration of therapy that are consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ Does not have a contraindication to the prescribed drug

Q3. For an osteoporosis-related condition, the member was evaluated for secondary causes of osteoporosis including complete blood count, vitamin D, ionized calcium, phosphorus, albumin, total protein, creatinine, liver enzymes (specifically alkaline phosphatase), intact parathyroid hormone, thyroid stimulating hormone, urinary calcium excretion, and testosterone (if a male)

☐ Yes ☐ No ☐ NA

Q4. The request is for an anabolic agent. If YES, go to 5. If NO, go to 12.

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☐ Yes ☐ No

Q5. For an anabolic agent, has a T-score of -3.5 or below, a T-score of -2.5 or below and a history of fragility fracture, or multiple vertebral fractures. If YES, go to 7. If NO, go to 6.

☐ Yes ☐ No

Q6. For an anabolic agent, has a history of therapeutic failure of or a contraindication or an intolerance to bisphosphonates.

☐ Yes ☐ No

Q7. For an anabolic agent, the member has not received a cumulative treatment duration that exceeds recommendations in the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q8. For an anabolic agent, For Forteo (teriparatide) and Tymlos (abaloparatide), the member DOES NOT have any of the following:

a. Paget's disease,
b. Bone metastases,
c. A history of skeletal malignancies,
d. Metabolic bone disease other than osteoporosis,
e. A hypercalcemic disorder,
f. Unexplained elevations of alkaline phosphatase,
g. Open epiphyses,
h. Prior external beam or implant radiation therapy involving the skeleton

☐ Yes ☐ No ☐ NA

Q9. For an anabolic agent, For Evenity (romosozumab), the member does not have a history of myocardial infarction or stroke?

☐ Yes ☐ No

Q10. For an anabolic agent, For Evenity (romosozumab) or Tymlos (abaloparatide), the member has a contraindication or an intolerance to teriparatide.

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☐ Yes ☐ No ☐ NA

Q11. For an anabolic agent, For Forteo (teriparatide) and Bonsity (teriparatide), has a contraindication or an intolerance to generic teriparatide that would not be expected to occur with the requested drug. If YES, go to 17.

☐ Yes ☐ No

Q12. The request is for Evista (raloxifene). If YES, go to 13. If NO, go to 16.

☐ Yes ☐ No

Q13. For Evista (raloxifene), all of the following:

☐ Does not have a history of venous thromboembolic events or breast cancer.

☐ For women with a risk factor for stroke (such as prior stroke or transient ischemic attack (TIA), atrial fibrillation, hypertension, or cigarette smoking), the increased risk of death due to stroke has been discussed with the beneficiary and documented by the prescriber.

Q14. 14. For Evista (raloxifene), The member is a postmenopausal woman at high risk of fracture2 and 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,
c. A 5-year predicted risk of breast cancer 1.66% (based on the modified Gail model)

If YES, go to 18. If NO, go to 15.

☐ Yes ☐ No

Q15. For Evista (raloxifene), the member is a postmenopausal woman at high risk of fracture2 with a history of therapeutic failure1 of or a contraindication or an intolerance to oral bisphosphonates. If YES, go to 18.

☐ Yes ☐ No

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Q16. For all other Bone Density Regulators, the request is for a denosumab 120 mg/1.7 mL product. If YES, go to 18. If NO, go to 17.

☐ Yes ☐ No

Q17. For all other Bone Density Regulators, the request is not for a denosumab 120 mg/1.7 mL product and all of the following:

☐ Is at high risk of fracture,

☐ Has a documented history of therapeutic failure1 of or a contraindication or an intolerance to the preferred Bone Density Regulators approved or medically accepted for the beneficiary's diagnosis,

☐ For a parenteral bisphosphonate, has a contraindication or an intolerance to oral bisphosphonates.

Q18. For a non-preferred Bone Density Regulator with a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug.

☐ Yes ☐ No

Q19. Based on the prescriber's assessment, the beneficiary's condition has stabilized and/or the beneficiary continues to benefit from the prescribed Bone Density Regulator.

☐ Yes ☐ No

Q20. For a non-preferred Bone Density Regulator with a therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that is preferred on the PDL, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred therapeutically equivalent brand/generic or corresponding biosimilar/brand biologic/unbranded biologic that would not be expected to occur with the requested drug.

☐ Yes ☐ No

Q21. Additional Information:

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Member Name:	Prescriber Name:

_____ _____

Prescriber Signature Date

v2026-06