Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tymlos

Fax back to: (833) 605-4407
Phone: (215) 991-4300

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.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

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 request for a patient who is currently receiving the requested medication? If YES, go to 2. If NO go to 4.

☐ Yes ☐ No

Q2. Has the patient exceeded a total of 24 months cumulative duration of parathyroid hormone analogs (teriparatide and abaloparatide) in the patient's lifetime?

☐ Yes ☐ No

Q3. Has the patient experienced any adverse effects?

☐ Yes ☐ No

Q4. Does the patient have Postmenopausal osteoporosis? If YES, go to 5. if NO, go to 7.

☐ Yes ☐ No

Q5. Does the patient have a history of fragility fractures (e.g., low trauma fracture from force similar to a fall from standing position) with supporting chart notes or medical records attached?

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tymlos

Fax back to: (833) 605-4407
Phone: (215) 991-4300

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.

Patient Name:	**Prescriber Name:**

☐ Yes ☐ No

Q6. Does the patient have a pre-treatment T-score less than or equal to -2.5 OR member has osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability and meets ANY of the following criteria:

☐ Member has indicators of very high fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores [less than or equal to -3], or increased fall risk)

☐ Member has failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (e.g., zoledronic acid [Reclast], denosumab [Prolia], teriparatide [Forteo, Bonsity])

☐ Member has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate.

Q7. Does the patient have a diagnosis of osteoporosis in men?

☐ Yes ☐ No

Q8. Does the patient have a history of an osteoporotic vertebral or hip fracture fractures (supporting chart notes or medical records attached)?

☐ Yes ☐ No

Q9. Does the patient meet both of the following criteria (supporting chart notes or medical records attached):

☐ Member has a pre-treatment T-score less than or equal to -2.5 OR member has osteopenia (i.e., pre-treatment T-score greater than -2.5 and less than -1) with a high pre-treatment FRAX fracture probability.

☐ Member has had an oral OR injectable bisphosphonate trial of at least 1-year duration OR there is a clinical reason to avoid treatment with a bisphosphonate.

Q10. Additional Information:

Prescriber Signature

Date

Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Tymlos

Fax back to: (833) 605-4407
Phone: (215) 991-4300

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.

Patient Name:	**Prescriber Name:**

v2026