BONE DENSITY REGULATORS PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines **Bone Density Regulators** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Dose/directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

Complete all sections that apply to the member and this request.

Check all that apply and submit documentation for each item.

INITIAL requests

1. For treatment of an OSTEOPOROSIS-RELATED condition:

☐Has results of a recent bone mineral density test → Document T-score: _____ Date of test: _____

☐Was evaluated for other possible causes of osteoporosis and has results of the following lab tests:

☐CBC	☐Phosphorous	☐Total protein	☐Thyroid stimulating hormone (TSH)
☐Vitamin D	☐Creatinine	☐Urinary calcium excretion	☐Intact parathyroid hormone (PTH)
☐Ionized calcium	☐Albumin	☐Testosterone (if male)	☐Liver enzymes (specifically alkaline phosphatase)

pa health & wellness

2. For an ANABOLIC AGENT (e.g., Bonsity, Evenity, Forteo, teriparatide):

- ☐ Has a history of fragility fracture
- ☐ Has a history of multiple vertebral fractures
- ☐ Has a history of trial and failure of or a contraindication or an intolerance to bisphosphonates
- ☐ Request will not exceed the cumulative treatment duration recommended in the FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

☐ **For a PARATHYROID HORMONE ANALOG (e.g., abaloparatide [Tymlos], teriparatide [e.g., Bonsity, Forteo])** – check all that apply to the member:

- ☐ Paget's disease of the bone
- ☐ Bone metastases
- ☐ History of skeletal malignancies
- ☐ Open epiphyses
- ☐ Metabolic bone disease other than osteoporosis
- ☐ Hypercalcemic disorder(s)
- ☐ Unexplained elevations of alkaline phosphatase
- ☐ Prior external beam or implant radiation therapy involving the skeleton

☐ **For EVENITY** – check all that apply to the member:

- ☐ History of myocardial infarction
- ☐ History of stroke

☐ **For EVENITY or TYMLOS:**

- ☐ Has a contraindication or an intolerance to teriparatide

☐ **For FORTEO and BONSITY:**

- ☐ Has a contraindication or an intolerance to generic teriparatide that would not be expected to occur with the requested drug

3. For EVISTA (raloxifene):

☐ Check all that apply to the member:

- ☐ History of venous thromboembolic events (including deep vein thrombosis, pulmonary embolism, and retinal vein thrombosis)
- ☐ History of breast cancer

☐ Has ONE or more risk factors for stroke:

- ☐ History of stroke or TIA
- ☐ Hypertension
- ☐ other: _____
- ☐ Atrial fibrillation
- ☐ Cigarette smoker

☐ If member has one or more risk factors for stroke, was counseled by the prescriber about the increased risk of death due to stroke

☐ Is a post-menopausal or post-oophorectomy female

☐ Is at high risk for fracture defined by at least ONE of the following:

- ☐ A 10-year probability of hip fracture ≥3% based on the US-adapted WHO algorithm
- ☐ A 10-year probability of major fracture related to osteoporosis ≥20% based on the US-adapted WHO algorithm
- ☐ A history of fragility fracture of the proximal humerus, pelvis, or distal forearm
- ☐ A history of low-trauma spine or hip fracture

☐ Is at high risk for invasive breast cancer defined by at least ONE of the following:

- ☐ Prior biopsy with lobular carcinoma in situ (LCIS) or atypical hyperplasia
- ☐ One or more first-degree relatives with breast cancer
- ☐ A 5-year predicted risk of breast cancer ≥1.66% (based on the modified Gail model)

☐ Has a history of trial and failure of or a contraindication or an intolerance to oral bisphosphonates

4. For DENOSUMAB 120 MG/1.7 ML (i.e., Xgeva and corresponding biosimilars), the member is being treated for at least ONE of the following:

- ☐ Bone metastases from solid tumors

☐ Giant cell tumor of the bone
☐ Hypercalcemia of malignancy
☐ Multiple myeloma
☐ A diagnosis not in the list above that is supported by FDA-approved package labeling, peer-reviewed medical literature, or nationally recognized medical compendia

5. For ALL OTHER Bone Density Regulators:

☐ Is at high risk for fracture defined by at least ONE of the following:
- ☐ A 10-year probability of hip fracture ≥3% based on the US-adapted WHO algorithm
- ☐ A 10-year probability of major fracture related to osteoporosis ≥20% based on the US-adapted WHO algorithm
- ☐ A history of fragility fracture of the proximal humerus, pelvis, or distal forearm
- ☐ A history of low-trauma spine or hip fracture

☐ Has a history of trial and failure of or a contraindication or an intolerance to the preferred Bone Density Regulators *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

☐ **For a PARENTERAL bisphosphonate:**
- ☐ Has a contraindication or an intolerance to oral bisphosphonates

RENEWAL requests

1. For ALL renewal requests:

☐ The member's condition has stabilized since starting the requested medication
☐ The member continues to benefit from the requested medication

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

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Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)