## Prior Authorization Form

# Forteo® (Teriparatide [rDNA origin] Injection

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

☐ **Forteo®**
Quantity___________ Refill x___________months
Instructions_______________________________________________
Physician's signature______________________ Provider NPI: _______________ MD# _______________
Date:_____________________ Date medication needed_____________________

**Patient Information**
Patient's name_______________________________
Patient's address_________________________
City, State, Zip: ___________________________________
Patient's phone # _______________________
Patient's ID#:__________________ DOB ____________

**Prescriber Information**
Prescribing physician_______________________
Office address_____________________________
City, State, Zip: ____________________________________
Office contact______________________________
Office #_____________________ Fax# _________________

Upon approval, delivery is available. Complete section below.

| ☐ **No Delivery Requested** | ☐ **Delivery Requested** |
|---|---|
| ☐ **Physician Supply, authorization only [Flex series]** | ☐ **Physician's office** ☐ **Patient's home** |
| ☐ **Member Pick up at pharmacy if benefit available** | **Preferred Vendor:** ____________________________ |

****A copy of the prescription must accompany the medication request****

### 1. DIAGNOSIS FOR DRUG REQUESTED

☐ Postmenopausal Osteoporosis 733.01 ☐ Primary Osteoporosis 733.0 ☐ Hypogonadal Osteoporosis
☐ Other (specify & include ICD-9)__________________________________

### 2. PATIENT'S INFORMATION:

| | | |
|---|---|---|
| **a.** Is the bone mineral density (BMD) score at least -2.5 SDs below the young adult mean? | ☐ Yes | ☐ No |
| **b.** Is the patient receiving a supplemental treatment with Calcium plus Vitamin D? | ☐ Yes | ☐ No |
| **c.** Does the patient have a history of osteoporosis fractures? | ☐ Yes | ☐ No |
| **d.** Does the patient have multiple risk factors for fractures? (i.e., advanced age, cigarette/alcohol usage, chronic steroid use, recurrent falls, fracture as an adult?) | ☐ Yes | ☐ No |
| **e.** Does the patient have a history of Pagets Disease, bone metastases, or skeletal malignancies or other metabolic bone disease beside osteoporosis? | ☐ Yes | ☐ No |
| **f.** Has the patient ever received skeletal radiation therapy? | ☐ Yes | ☐ No |
| **g.** Does the patient have hypercalcemia? | ☐ Yes | ☐ No |
| **h.** Does the patient have a history of unexplained high levels of alkaline phosphatase in the blood? | ☐ Yes | ☐ No |

### 3. PATIENT HISTORY

History of failed osteoporosis drug therapy:

| **Drug name** | **Dates** | **Duration** |
|---|---|---|
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |
| ____________ | ____________ | ____________ |

Please add any other supporting medical information that may be useful in the decision-making process:
___________________________________________________________
___________________________________________________________

**FAX TO (215) 761-9165 YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**

**Internal use only**
Document #______________________
M F Rx coverage Y N
Previous Auth Y N
**Approved** **Reviewer Initials**______________
Vendor_________________
LOB_______________
STANDARD - SELECT
Auth#_____________________
Date_______________Coverage effective date / /
Billing Code_____________ **M / Rx**
Processor Initials____________
Date____________________
From______________ To_____________

**Internal: For the COMMERCIAL PHARMACY BENEFIT ONLY (2c, 2d, 3)**


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