AmeriHealth

## 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** Vendor_____ Billing Code_____ **M / Rx**
Document #_____ LOB_____ Processor Initials_____
M F Rx coverage Y N STANDARD - SELECT Date_____
Previous Auth Y N Auth#_____ From_____ To_____
**Approved** **Reviewer Initials**_____ Date_____Coverage effective date / /