



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'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. Does the patient have a history of osteoporosis fractures?

Yes

No

b. 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

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 _____