



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? 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?)

3. PATIENT HISTORY

History of failed osteoporosis drug therapy:

Table with 3 columns: Drug name, Dates, Duration

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

FAX TO (888) 671-5285 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 Date Coverage effective date / / Vendor LOB STANDARD - SELECT Auth# Billing Code M / Rx Processor Initials Date From To