Please complete ALL information below and fax your request to 1-888-671-5285

Forteo® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

- ❑ Glucocorticoid-induced osteoporosis* in men or women (taking a daily dose greater than or equal to 5 mg prednisone or its equivalent for at least 3 months)
- ❑ Postmenopausal osteoporosis*
- ❑ Primary or hypogonadal osteoporosis* in men
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

**Please note: Osteoporosis is defined as a T-score of the individual's bone mineral density (BMD) of at least -2.5 standard deviations below the young adult mean or history of osteoporotic fracture (i.e., hip, spine, etc.)*

Clinical Information:

Select if the patient has high risk for fracture as defined by the following:

- ❑ History of osteoporotic fractures
- ❑ At least two (2) risk factors for a fracture (e.g., endocrine disorders, gastrointestinal disorders, use of medications associated with low bone mass or bone loss such as corticosteroids)

Select if the patient has had an inadequate response or inability to tolerate the following osteoporosis therapies:

- ❑ Bisphosphonates
- ❑ Hormone replacement therapy
- ❑ Selective-estrogen receptor modulators (SERMs)
- ❑ Calcitonin-salmon (Miacalcin)
- ❑ Denosumab (Prolia) [for diagnosis of glucocorticoid-induced osteoporosis in men or women OR postmenopausal osteoporosis only]

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.