



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

Forteo® Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> 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)	
<input type="checkbox"/> Postmenopausal osteoporosis*	
<input type="checkbox"/> Primary or hypogonadal osteoporosis* in men	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<i>*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.)</i>	

<p>Clinical Information:</p> <p>Select if the patient has high risk for fracture as defined by the following:</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of osteoporotic fractures <input type="checkbox"/> 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) <p>Select if the patient has had an inadequate response or inability to tolerate the following osteoporosis therapies:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bisphosphonates <input type="checkbox"/> Hormone replacement therapy <input type="checkbox"/> Selective-estrogen receptor modulators (SERMs) <input type="checkbox"/> Calcitonin-salmon (Miacalcin) <input type="checkbox"/> Denosumab (Prolia) [for diagnosis of glucocorticoid-induced osteoporosis in men or women <u>OR</u> 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.

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