

Fax completed form to: 1-866-868-0858  
Questions, please call: 1-866-316-6049



**Important Information About Prescription Drug Coverage**

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To: \_\_\_\_\_ From: \_\_\_\_\_

Fax: \_\_\_\_\_ Pages: \_\_\_\_\_

Re: Forteo® (teriparatide): Prior Authorization Request Form: Please respond.

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- Please complete the attached Forteo® (teriparatide) Prior Authorization Request Form
- To expedite the review process please complete all requested fields.
- Completed forms should be faxed to: 1-866-868-0858. It is not necessary to fax this cover page.

**Please note:** By signing the attached form you are certifying that the treatment requested is medically necessary. No contraindications are present and precautions have been considered. You will be supervising the patient’s treatment. Supporting documentation is available in the patient’s record. Signature on this form attests to the fact that the corresponding ICD-9 code has been documented in the patients chart and submitted on a CMS- 1500 form.

**Information about this drug**

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**Forteo® (teriparatide)**  
Forteo® should only be considered as a tertiary treatment option for osteoporosis. Please consider the following agents if appropriate: Fosamax® (alendronate), Actonel® (risendronate), Miacalcin® (calcitonin), or Evista® (raloxifene).

You can make an expedited request by indicating this at the top of the attached form. If you request an expedited review, and sign the attached form, you certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member’s ability to regain maximum function.

**Information on the attached form is protected health information and subject to all privacy and security regulations under HIPAA.**

# Prior Authorization Request Form

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## Patient Information

Name \_\_\_\_\_  
Member ID \_\_\_\_\_  
Medicare ID \_\_\_\_\_  
Date of birth \_\_\_\_\_ Sex: M / F  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_  
Nursing home resident? YES / NO  
Home care patient? YES / NO

## Prescriber and Pharmacy Information

Name \_\_\_\_\_  
Specialty \_\_\_\_\_  
DEA \_\_\_\_\_  
NPI \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_ ZIP \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Pharmacy name \_\_\_\_\_  
NCPDP \_\_\_\_\_  
NPI \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_

## All items below this line are for Physician Use Only

### Information for Requested Drug

Strength: \_\_\_\_\_ Dosage form: \_\_\_\_\_ Qty per 30 days: \_\_\_\_\_ Drug is (circle one): Newly prescribed/Refill  
Directions: \_\_\_\_\_ Diagnosis: \_\_\_\_\_ ICD-9 Code: \_\_\_\_\_

Standard Reviews will be completed in under 72 hours. An expedited review is available if you certify that a standard review timeframe will seriously jeopardize the health of your patient. To request an expedited review, simply indicate this at the top of this page.

### Forteo® (teriparatide) Criteria

- 1 Is Forteo® being provided by a home health agency and is coverage under Medicare Part B available?  
 Yes  No  
• If yes, Medicare Part B will be billed. Forteo® is covered under Medicare Part B when provided by a home health agency to female beneficiaries who meet the criteria established in the Medicare Benefit Policy Manual (e.g., post-menopausal osteoporosis bone fracture and unable to self-administer) and the Medicare coverage criteria for the home health benefit.
  - 2 Please indicate the patient's diagnosis. Select or indicate the correct ICD-9 code. This question must be completed.  
 Postmenopausal Osteoporosis (ICD-9: 733)  
 Primary or Hypogonadal Osteoporosis (ICD-9: 733)  
 Other (diagnosis and ICD-9 code) \_\_\_\_\_
  - 3 Does the patient have a history of any of the following? (check any that apply)  
 Yes  No  
 Paget's Disease  
 Prior radiation therapy  
 Bone metastasis  
 Metabolic bone disease
  - 4  Pre-existing hypercalcemia  
Bone Mineral Density results: T-score at hip:  
 < -1  
 < -2.5  
 < -3
  - 5 Bone Mineral Density results: T-score at spine:  
 < -1  
 < -2.5  
 < -3
  - 6 Has the patient had at least one osteoporotic fracture?  
 Yes  No
  - 7 Has the patient failed to receive a clinically appropriate response or demonstrated intolerance to Actonel®, Fosamax®, Miacalcin®, or Evista®?  
 Yes  No
- Note: To ensure treatment success, patients should also be receiving calcium 1200 - 1500 mg /day and vitamin D 400 IU /day. Forteo® is not approved for use with concomitant bisphosphonate therapy.

Medical justification: (Attach additional page if necessary): \_\_\_\_\_

Prescriber's signature: \_\_\_\_\_ Date: \_\_\_\_\_