

Fax completed form to: 1-866-868-0858

Questions, please call: 1-866-316-6049

TODAY'S HEALTH

Important Information About Prescription Drug Coverage

To: _____ From: _____

Fax: _____ Pages: _____

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

- 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

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.

MemberHealth, LLC, PO Box 391197, Solon OH 44139-3911

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M0018_PATEMP_1107 CMS 11/28/07 H8742

Prior Authorization Request Form

Fax completed form to 1-866-868-0858 Need help? Call 1-866-316-6049

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 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: _____