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 Supply, authorization only [Flex series]**	☐ **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:

Question		
a. Is the bone mineral density (BMD) score at least -2.5 SDs below the young adult mean?	☐ Yes	☐ No
b. Is the patient receiving a supplemental treatment with Calcium plus Vitamin D?	☐ Yes	☐ No
c. Does the patient have a history of osteoporosis fractures?	☐ Yes	☐ No
d. 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?)	☐ Yes	☐ No
e. Does the patient have a history of Pagets Disease, bone metastases, or skeletal malignancies or other metabolic bone disease beside osteoporosis?	☐ Yes	☐ No
f. Has the patient ever received skeletal radiation therapy?	☐ Yes	☐ No
g. Does the patient have hypercalcemia?	☐ Yes	☐ No
h. Does the patient have a history of unexplained high levels of alkaline phosphatase in the blood?	☐ Yes	☐ No

3. PATIENT HISTORY

History of failed osteoporosis drug therapy:

Drug name	**Dates**	**Duration**
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

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

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FAX TO (215) 761-9165 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**_______________

Vendor___________________
LOB_________________
STANDARD - SELECT
Auth#__________________________
Date________________Coverage effective date / /

Billing Code______________ **M / Rx**
Processor Initials____________
Date____________________
From______________ To_____________

Independence Blue Cross offers products directly, through its subsidiaries Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield.
Independent licensees of the Blue Cross and Blue Shield Association.