Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION BYPASS

Forteo® (teriparatide recombinant)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name ____________________

Address ____________________

℞

Refer for Anabolic Protocol for Osteoporosis

MD ____________________

Signature ____________________

Name ____________________

Address ____________________

℞

Compound oxandrolone 1mg for women; 5mg for men quantity: #

sig: 1 orally 5x/wk

as directed by physician

Dx: OSTEOPOROSIS

ICD 10: M 81.0

MD ____________________

Signature ____________________

SAMPLE

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone: ___ - ___ - ____	Fax: ___ - ___ - ____

Member Information

Last Name:	First Name
Member ID Number	DOB: __ - __ - ____

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Forteo (teriparatide recombinant) Prior Authorization Form

You must answer ALL of the following questions		
1. Is the patient 18 years of age or older?	Y	N
2. Is the patient a female with postmenopausal osteoporosis?	Y	N
3. Is the patient a male with idiopathic or hypogonadal osteoporosis?	Y	N
4. Does the patient have osteoporosis associated with systemic glucocorticoid therapy of 3 months duration or greater? *Please provide dates of chronic steroid use*__________________	Y	N
5. Has the patient ever been treated with a bisphosphonate?	Y	N
6. Does the patient have reflux/GERD OR severe renal disease, as defined by a CrCl less than 35mL/min? *Please provide documentation.*	Y	N
7. Has the patient failed previous treatment with at least one bisphosphonate (i.e., Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate), or Reclast)?	Y	N
8. Was the treatment failure measured by a decline in bone mineral density in g/cm^2 of greater than or equal to 3% in the spine and/or hip while on bisphosphonate therapy? *Please provide documentation.*	Y	N
9. Was the treatment failure due to a fracture while being treated with bisphosphonate therapy and did this fracture occur in the past 3 years? *Please provide documentation.*	Y	N
10. Has the patient been intolerant to previous treatment with at least one bisphosphonate (i.e., Fosamax (alendronate), Actonel (risedronate), Boniva (ibandronate) or Reclast)? *Please provide documentation.*	Y	N

Please note, not all drugs/diagnoses are covered on all plans.

Comments: ____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

____ ________________________

Prescriber or Authorized Signature **Date**

____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Department whose numbers appear on the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

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PRIOR AUTHORIZATION FORM: COVER PAGE

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	
DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			
PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.			
Medication/Failure Reason:			

IgE:______________

ESR:_______________ **CRP:**_______________ **# Joints:**_______________ **%BSA:**______________

Height:_______________ **Weight:**_______________ **BMI:**_______________

HA1C:_______________ **Hemoglobin:**_______________ **Hematocrit:**_______________ **T-Score:**_____________

Dialysis:_____________ **Long Term Care Facility:**_____________ **Self Injecting:**_____________

Stimulation test:__________/__________ **Growth velocity:**___________ **#Chemotherapy cycles/month:**__________

Mini-Mental Status Test:____________ **Baseline Free testosterone/Total testosterone:**__________/_________

HCV RNA viral load:______________ **Viral Genotype:**_______________ **ALT:**_______________

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	

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