

Pharmacy Prior Authorization Form

Last Reviewed: Sept. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Forteo[®] (teriparatide)

Urgent Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

Forteo Injection 250 mcg/ml

Dose: _____ Start date: _____

Priority Health Precertification Requirements:

Authorization of Forteo requires:

- History of an osteoporotic fracture

OR

- Documented therapeutic trial of at least two of the following formulary alternatives:
 - Fosamax
 - Actonel
 - Boniva
 - Miacalcin

Please complete the following information:

Does the patient have an osteoporotic fracture? Yes No

Has the patient received a therapeutic trial and clinical failure of at least **two** of the following agents:

	Dose	Dates	Outcome
<input type="checkbox"/> Fosamax	_____	_____	_____
<input type="checkbox"/> Actonel	_____	_____	_____
<input type="checkbox"/> Boniva	_____	_____	_____
<input type="checkbox"/> Miacalcin	_____	_____	_____

If member has not had trial of alternatives, please provide rationale for use: _____

Patient be self-administering the medication?

- Yes
- No – Medication will be given by _____



***** All fields must be complete and legible for Prior Authorization Review*****
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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX