

# Pharmacy Prior Authorization Form

Last Reviewed: Sept. 11

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<sup>®</sup> (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 \_\_\_\_\_

**For Medicare only:** If none of the above is applicable to this member, please check which, if any, of the following apply:

- All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
  
- The number of doses available under a dose restriction for the prescription drug:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition or,
  - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance
  
- The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
  - Has been ineffective in the treatment of the enrollee's disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
  - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
  
- None of the above apply

**\*\*\* All fields must be complete and legible for Prior Authorization Review\*\*\*  
Please fax this request to: (877)974-4411 toll free or (616)942-8206  
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**