PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☒ **Commercial (Traditional)** ☒ **Commercial (Individual/Optimized)** ☐ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Forteo® (teriparatide)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☒ Forteo prefilled pen 20 mcg/dose

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must either:

1. For osteoporosis, whether postmenopausal, primary or hypogonadal, or due to corticosteroids, in patients with **no history** of an osteoporotic fracture, the patient:
   - must try one of the following: alendronate, Actonel, *or* ibandronate; *and*
   - must try zoledronic acid (generic Reclast) *or* Prolia*; *and*
   - must try Tymlos (if for postmenopausal osteoporosis).

—or—

2. For osteoporosis, whether postmenopausal, primary or hypogonadal, or due to corticosteroids, in patients **who have a history** of an osteoporotic fracture, the patient:
   - must try one of the following: alendronate, ibandronate, risedronate, zoledronic acid (generic Reclast), *or* Prolia*; *and*
   - experience an additional osteoporotic fracture while on one of above therapies.
   - If using for diagnosis of postmenopausal osteoporosis, must first try Tymlos (in addition to the above) before Forteo will be approved.

***Prolia requires prior authorization.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 09/2018

Last reviewed 09/2018

Additional information

Note: Parathyroid hormone treatment may be authorized for up to two years in a lifetime. For example, Priority Health will not authorize Forteo if Tymlos has already been used for two years. Additional efficacy beyond two years has not been established.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Osteoporosis
  - ☐ Primary or hypogonadal
  - ☐ Due to corticosteroids
  - ☐ Postmenopausal
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. What is the patient's baseline DEXA T-score? _____ Date: _____

C. Has the patient had one or more osteoporotic fractures?

- ☐ Yes Date(s): _____
- ☐ No

D. Which of the following medications has the patient had a therapeutic trial with?

- ☐ alendronate (generic for Fosamax)
- ☐ ibandronate (generic for Boniva)
- ☐ risedronate (generic for Actonel)

E. Which of the following infused medications has the patient had a therapeutic trial with?

- ☐ zoledronic acid (generic Reclast)
- ☐ Prolia

F. Has the member tried Tymlos?

- ☐ Yes
- ☐ No; rationale: _____

G. What failure, contraindication, or intolerance occurred on these therapies?

- ☐ Creatinine clearance < 35 mL/min
  - Drug: _____
  - *CrCl:* _____ *Date of most recent SCr lab:* _____
- ☐ Significant decrease in BMD despite compliance
  - Drug: _____
  - *Baseline BMD results:* _____ *Recent (on-therapy) BMD results:* _____
- ☐ New fracture while on therapy despite compliance
  - Drug: _____
  - *Date(s) of fracture:* _____ *Date(s) of use:* _____
- ☐ Other: _____

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Last reviewed 09/2018