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 meet the following:

1. For the treatment of osteoporosis in postmenopausal women, must have a T-score less than or equal to -3 with a previous low-impact fracture, and meet **all** of the following:
   - o Documented failure of an oral bisphosphonate (or documented intolerance or contraindication) despite compliance for at least 2 years (Note: Failure of any trials (including drugs below) is defined by new fracture while on treatment or reduction in bone mineral density (BMD) per recent DEXA scan).
   - o Documented failure or intolerance to a compliant (at least 12 month) regimen of zoledronic acid (generic Reclast).
   - o Documented failure of Tymlos (*also requires a prior authorization*)

2. For the treatment of osteoporosis in men, must have a T-score less than or equal to -3 with a previous low-impact fracture, and meet **all** of the following:
   - o Documented failure of an oral bisphosphonate (or documented intolerance or contraindication) despite compliance for at least 2 years (Note: Failure of any trials (including drugs below) is defined by new fracture while on treatment or reduction in bone mineral density (BMD) per recent DEXA scan).
   - o Documented failure or intolerance to a compliant (at least 12 month) regimen of zoledronic acid (generic Reclast).

3. For the treatment of corticosteroid-induced osteoporosis, must have a T-score less than or equal to -1, and meet **all** of the following:
   - o Documented failure of an oral bisphosphonate (or documented intolerance or contraindication) despite compliance for at least 2 years (Note: Failure of any trials (including drugs below) is defined by new fracture while on treatment or reduction in bone mineral density (BMD) per recent DEXA scan).
   - o Documented failure or intolerance to a compliant (at least 12 month) regimen of zoledronic acid (generic Reclast).

4. For the treatment of hypoparathyroidism, must have parathyroid hormone level (PTH) checked to rule our hyperparathyroidism, and meet the following:
   - o Trial and failure/intolerance to a compliant (at least 2 months) regimen of at least one formulary medication used to treat hypoparathyroidism (i.e. calcitriol or ergocalciferol).

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 09/2019

Additional information

Note: Parathyroid hormone analogs will be authorized for up to a total of two years in a lifetime. Additional efficacy beyond two years has not been established. Also, if member has a new fracture while on a bisphosphonate, a clinical trial is only required for one bisphosphonate (oral or IV).

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 in postmenopausal women
- ☐ Osteoporosis in men
- ☐ Corticosteroid-induced osteoporosis
- ☐ Hypoparathyroidism
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

Osteoporosis

A. Has the patient had a low-impact fracture?

- ☐ Yes Date(s): _____
- ☐ No

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

C. Has the patient tried one of the following for at least 2 years (check all that apply)?

- ☐ alendronate (generic Fosamax)
- ☐ risedronate (generic Actonel) **Date(s) of use:** _____
- ☐ ibandronate (generic Boniva)
- ☐ None; *Rationale*: _____

What failure, contraindication, or intolerance occurred?

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

D. Has the patient tried zoledronic acid for at least 1 year?

- ☐ Yes Date(s): _____
- ☐ No

What failure, contraindication, or intolerance occurred?

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

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E. Has the patient tried Tymlos (*for postmenopausal osteoporosis*)**?**

☐ Yes Date(s): _____

☐ No

What failure, contraindication, or intolerance occurred?

☐ Significant decrease in BMD despite compliance

Baseline BMD results: _____ *Recent (on-therapy) BMD results:* _____

☐ New fracture while on therapy despite compliance

*Date(s) of fracture:*_____ *Date(s) of use:*_____

☐ Other: _____

Hypoparathyroidism

A. Parathyroid hormone level: _____ **Date:** _____

B. Has the patient been tried and failed one other medication for this condition for at least 2 months?

☐ Yes

Medication: _____ Dates used: _____ Outcome: _____

Medication: _____ Dates used: _____ Outcome: _____

☐ No

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