Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Medicare Part B** ☒ **Medicare Part D**
This request is: ☐ **Expedited request** ☐ **Standard request**

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

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

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

For this drug to be covered, the patient must meet the following criteria:

1. Must be treating osteoporosis (postmenopausal with high risk of fracture, primary or hypogonadal in men, or due to corticosteroids) or another medically-accepted indication*
2. For postmenopausal osteoporosis: Must have a documented therapeutic trial with failure, contraindication, or intolerance to:
    - Alendronate, risedronate or ibandronate defined as ***one*** of the following:
        - Creatinine clearance less than 35 mL/min
        - Inability to remain upright for 30 minutes after dose
        - Esophageal stricture (known stricture or dysphagia)
        - Significant decrease in BMD after at least one year of therapy
        - New fracture while on therapy

        - OR -
    - Zoledronic acid or Prolia defined as ***one*** of the following:
        - Significant decrease in BMD after at least one year of therapy
        - New fracture while on therapy

        - AND -
    - Tymlos defined as ***one*** of the following:
        - Significant decrease in BMD after at least one year of therapy
        - New fracture while on therapy

All fields must be complete and legible for review. Your office will receive a response via fax.
Updated 01/2019
Last reviewed 01/2019

3. For primary or hypogonadal osteoporosis in men or osteoporosis due to corticosteroids: Must have a documented therapeutic trial with failure, contraindication, or intolerance to:
    - Alendronate, risedronate or ibandronate defined as ***one*** of the following:
        - Creatinine clearance less than 35 mL/min
        - Inability to remain upright for 30 minutes after dose
        - Esophageal stricture (known stricture or dysphagia)
        - Significant decrease in BMD after at least one year of therapy
        - New fracture while on therapy

        - AND -
    - Zoledronic acid or Prolia defined as ***one*** of the following:
        - Significant decrease in BMD after at least one year of therapy
        - New fracture while on therapy
4. Patient's T-score must be provided

Additional information

Note: If approved, coverage is approved for up to 2 years of total therapy (inclusive of all parathyroid hormone analogs).

Medically-accepted indication*

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — *or* — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System)

Priority Health Precertification Documentation

A. What is the patient's T-score?_____ **Date T-score obtained:**_____

B. What condition is this drug being requested for?

- ☐ Osteoporosis
    - ☐ Primary or hypogonadal in men
    - ☐ Due to corticosteroids
    - ☐ Postmenopausal, high risk of fracture
- ☐ *Other – the patient's condition is:* _____

Rationale for Other use: _____

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 Fosamax)
- ☐ risedronate (generic Actonel)
- ☐ ibandronate (generic Boniva)
- ☐ zoledronic acid (generic Reclast)
- ☐ Prolia
- ☐ None. **Are you requesting an exception to the criteria?**
    - ☐ Yes. ***Rationale for exception***: _____
    - ☐ No

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E. What failure, contraindication, or intolerance applies to use of alendronate, risedronate or ibandronate?

- ☐ Creatinine clearance < 35 mL/min. *CrCl:* _____ *Date of most recent SCr lab:* _____
- ☐ Inability to remain upright for 30 minutes after dose
- ☐ Esophageal stricture (stricture or dysphagia)
- ☐ Significant decrease in BMD after at least one year of therapy. *Date(s) of use:* _____
- ☐ New fracture while on therapy. *Date(s) of fracture:* _____ *Date(s) of use:* _____
- ☐ None. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

F. What failure, contraindication, or intolerance applies to use of zoledronic acid or Prolia?

- ☐ Significant decrease in BMD after at least one year of therapy. *Date(s) of use:* _____
- ☐ New fracture while on therapy. *Date(s) of fracture:* _____ *Date(s) of use:* _____
- ☐ None. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

G. For postmenopausal osteoporosis, has the patient tried Tymlos?

- ☐ Yes
- ☐ No. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

H. For postmenopausal osteoporosis, what failure, contraindication, or intolerance applies to use of Tymlos?

- ☐ Significant decrease in BMD after at least one year of therapy. *Date(s) of use:* _____
- ☐ New fracture while on therapy. *Date(s) of fracture:* _____ *Date(s) of use:* _____
- ☐ None. **Are you requesting an exception to the criteria?**
  - ☐ Yes. ***Rationale for exception***: _____
  - ☐ No

Priority Health Medicare Exception Request *(exceptions to the above criteria)*

Do you believe one or more of the prior authorization requirements should be waived? ☐ Yes ☐ No
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

Would Forteo likely be the most effective option for this patient?
☐ Yes ☐ No
If yes, please explain why: _____

_____

_____

If the patient is currently using Forteo, would changing the patient's current regimen likely result in adverse effects for the patient?
☐ Yes ☐ No
If yes, please explain: _____

_____

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