FORM # FRX0029

Prior Authorization Request Form for Forteo (teriparatide)

Member Information

Patient Name ____________________________

Cardholder ID ___________________________

Date of Birth ___________________________

Address ________________________________

City, State Zip __________________________

Phone Number ___________________________

Provider Information

Provider Name ____________________________

DEA Number ______________________________

Address _________________________________

City, State and Zip ________________________

Phone Number ____________________________

FAX Number _____________________________

Pharmacy Information

Pharmacy Name___________________Address__________________Phone______________________

Criteria for Approval:

1. Does the patient have a diagnosis of postmenopausal osteoporosis or hypogonadal osteoporosis? Yes ☐ No ☐
2. Does the patient have a diagnosis of Paget's disease? Yes ☐ No ☐
3. Has the patient recently been treated with radiation involving the skeleton? Yes ☐ No ☐
4. Has the patient been of Forteo for the previous six months? Yes ☐ No ☐
5. Does the patient have multiple risk factors for fractures? Yes ☐ No ☐
   ☐ History of osteoporotic fractures ☐ Very low bone mineral density (BMD)
   ☐ Frequent falls ☐ Limited movement ☐ Open epiphysis
   ☐ Unexplained elevated levels of alkaline phosphatase ☐ Medical condition or medications likely to cause bone fractures
6. Has the patient tried and failed at least one osteoporosis treatment? *Check all that apply:* Yes ☐ No ☐
   ☐Biphosphonates ☐ Testosterone ☐ SERMs (evista) ☐ Calcitonin (Miacalcin)
7. Does the patient have bone cancer? Yes ☐ No ☐
8. Does the patient have hypercalcemia? Yes ☐ No ☐

Provider Signature ____ Date ________________________

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received____

Reference Number____

Approved / Denied (Circle One) by _____________________________ Date_______________________

Date/Time Returned to Provider____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

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