Prior Authorization Form

Forteo® (Teriparatide [rDNA origin] Injection

ONLY COMPLETED REQUESTS WILL BE REVIEWED

☐ **Forteo®**

Quantity____________ Refill x____________months

Instructions____

Physician's signature_________________________ Provider NPI: __________________ MD# __________________________

Date:_____________________ Date medication needed______________________

Patient Information

Patient's name___________________________________

Patient's address____________________________

City, State, Zip: ____

Patient's phone # __________________________

Patient's ID#:___________________ DOB _____________

Prescriber Information

Prescribing physician__________________________

Office address________________________________

City, State, Zip: ____

Office contact_________________________________

Office #______________________ Fax# ____________________

Upon approval, delivery is available. Complete section below.

☐ **No Delivery Requested**	☐ **Delivery Requested**
☐ **Physician Supply, authorization only [Flex series]**	☐ **Physician's office** ☐ **Patient's home**
☐ **Member Pick up at pharmacy if benefit available**	**Preferred Vendor:** _______________________________________

****A copy of the prescription must accompany the medication request****

1. DIAGNOSIS FOR DRUG REQUESTED

☐ Postmenopausal Osteoporosis 733.01 ☐ Primary Osteoporosis 733.0 ☐ Hypogonadal Osteoporosis

☐ Other (specify & include ICD-9)_____________________________________

2. PATIENT'S INFORMATION:

a. Does the patient have a history of osteoporosis fractures? ☐ Yes ☐ No

b. Does the patient have multiple risk factors for fractures? ☐ Yes ☐ No

(i.e., advanced age, cigarette/alcohol usage, chronic steroid use, recurrent falls, fracture as an adult?)

3. PATIENT HISTORY

History of failed osteoporosis drug therapy:

Drug name	Dates	Duration
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________
__________________________	__________________________	__________________________

Please add any other supporting medical information that may be useful in the decision-making process:

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FAX: (888) 671-5285 or EMAIL: FSS_Standard_Medicare@catalystrx.com

YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL

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