04/18/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Forteo (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Forteo (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Forteo (teriparatide)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis:_____ **ICD Code:**_____

Please circle the appropriate answer for each question.

1. Is the patient an adult greater than 18 years of age? Y N

   [If no, no further questions.]

2. Has the patient received a total of 24 months of Forteo therapy? Y N

   [If yes, no further questions.]

3. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under Aetna Better Health)? Y N

[If yes, skip to question 12.]

4. Is Forteo being used for the treatment of corticosteroid-induced osteoporosis? Y N

   [If no, skip to question 7.]

5. Does the patient have a baseline T-score less than or equal to -1.0? Please document T-score and date here: Y N

   [If yes, skip to question 11.]

6. Does the patient meet ONE of the following? Please list the medication tried and document intolerance, contraindication, or failure here (include T-score and date, if applicable): Y N

   Documented failure of consecutive 6 month regimen of at least one formulary bisphosphonate (i.e. decrease in T-score in comparison with baseline T-score from DEXA scan or new fracture) OR \ Documented contraindication or intolerance to at least one formulary bisphosphonate (for any length of time)

   [If yes, skip to question 11.]

   [If no, no further questions.]

7. Is Forteo being requested for the treatment of hypoparathyroidism? Please document parathyroid hormone level drawn within 30 days here: Y N

   _____

   [If no, skip to question 9.]

8. Does the patient meet ONE of the following? Please list the medication tried and document intolerance/contraindication: Y N

   _____

   Trial of a compliant regimen of at least one formulary medication used to treat hypoparathyroidism (Calcijex/Rocaltrol, ergocalciferol) OR \ Documented contraindication or intolerance to at least one formulary medication (for any length of time)

   [If yes, skip to question 11.]

   [If no, no further questions.]

9. Is Forteo requested for the treatment of osteoporosis? Y N

   [If no, no further questions.]

10. Does the patient meet ONE of the following? Please list the medication tried and document intolerance, contraindication, or failure here (include T-score and date, if applicable): Y N

    Documented contraindication or intolerance to at least one formulary oral bisphosphonate (e.g., alendronate) OR / Documented failure of consecutive 6 month regimen of a formulary oral bisphosphonate (i.e., decrease in T-score in comparison with baseline T-score from DEXA scan or new fracture)

    [If no, no further questions.]

11. Is the patient at increased baseline risk for osteosarcoma (e.g., Paget's disease of bone or unexplained elevations of alkaline phosphatase, open epiphyses, or prior external beam or implant radiation therapy involving the skeleton)? Y N

    [No further questions.]

12. Is the patient responding to treatment? For hypoparathyroidism, please document parathyroid hormone pretreatment level, current level, and dates drawn here: Y N

    _____

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature **Date**