Forteo

Express Scripts
Prior Authorization
Phone 1-844-424-8886
Fax 1-877-328-9799

Member's Last Name:	Member's First Name:
SCAN ID number:	Date of Birth:
Prescriber's Name:	Contact Person:
Office phone:	Office Fax:

Medication:	Diagnosis:

SECTION A Please answer the following questions

1. Is the diagnosis or indication for the treatment of one of the following: 1. Treatment of osteoporosis in postmenopausal women; 2. Increase bone mass in men with primary or hypogonadal osteoporosis; OR 3. Treatment of glucocorticoid-induced osteoporosis?
   - θ Yes (Document indication provided) _____
   - θ No (Document indication provided) _____
2. θ Yes θ No Does the patient have an increased baseline risk for osteosarcoma (e.g., those with Paget's disease of bone or unexplained elevations of alkaline phosphatase, pediatric and young adult patients with open epiphyses, or prior external beam or implant radiation therapy involving the skeleton)?
3. θ Yes θ No Does the patient have a documented history of one of the following: 1. The patient is at high risk for fractures (e.g., BMD T score below -2.5, or steroids use) or has a history of an osteoporotic fracture; OR 2. The patient had a fracture and/or experienced a decrease in BMD T score while on either alendronate (Fosamax), Atelvia, or ibandronate (Boniva); OR 3. The patient is not a candidate for bisphosphonates or intolerant to them?

Please document the symptoms and/or any other information important to this review:

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SECTION B Physician Signature

PHYSICIAN SIGNATURE _____ DATE _____

FAX COMPLETED FORM TO: 1-877-328-9799

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at http://www.villagehealthca.com.