

FORTEO (Non-Preferred)
PRIOR AUTHORIZATION FORM

Forteo is a Non-Preferred agent on the Medical Assistance Preferred Drug List (PDL). To review the prior authorization guidelines, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter-Bone Resorption Suppression & Related Agents (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)
Pages in this Request: _____ Office Contact Name: _____ Phone: (____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____
NPI#: _____ OR MA Provider ID#: _____ State License#: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone: (____) _____ Fax: (____) _____
Long-term care facility (if applicable) contact name: _____ Phone: (____) _____

MEDICAL INFORMATION

Forteo Dosing: 20 mcg SQ daily Other: _____ **Quantity:** _____ **Refills:** _____

Diagnosis: _____ **Diagnosis Code:** _____ (required)

Which Specialty pharmacy will be used? Diplomat Specialty Pharmacy Walgreens Specialty Pharmacy

Initial Requests

1. Does the Recipient have documentation of a bone density test? Yes – submit documentation No
2. Does the Recipient have documentation of the 10-year risk of fracture due to osteoporosis (based on the World Health Organization algorithm)? Yes – submit documentation No
3. Has the Recipient had any of the following lab tests performed to evaluate for other possible causes of osteoporosis (check all that apply & submit documentation)? Complete Blood Count Vitamin D Ionized calcium
 Phosphorus Albumin Total Protein Creatinine Liver enzymes (alkaline phosphatase)
 Intact Parathyroid Hormone (PTH) Thyroid Stimulating Hormone Urinary Calcium Excretion
 Testosterone (if male)
4. Does the Recipient have a history of any of the following (check all that apply & submit documentation)?
 Paget's Disease Bone metastases Skeletal malignancy Metabolic bone disease other than osteoporosis
 Prior external beam or implant radiation therapy involving the skeleton Hypercalcemic disorders
 Unexplained elevations of alkaline phosphatase Open epiphyses
5. Has the Recipient tried & failed (or have a contraindication or intolerance to) any of the oral bisphosphonate agents (check all that apply & submit documentation)?
 Actonel alendronate (tablet or solution) Atelvia DR Binosto Boniva Fosamax
 Fosamax Plus D ibandronate risedronate risedronate DR Other: _____
6. Has the Recipient previously been on Forteo?
 Yes – note how long: _____ and submit documentation No

Renewal Requests

1. Since Forteo was last approved, has the recipient had a follow-up bone density test performed?
 Yes – submit documentation No

PLEASE FAX COMPLETED FORM WITH CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ **Date:** _____

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