PRO ACT PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Forteo® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Glucocorticoid-induced osteoporosis in men and women at high risk for fracture
❑ Osteoporosis – To increase bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture
❑ Osteoporosis – For postmenopausal women at high risk for fracture
❑ Other diagnosis:_____ICD-10 Code(s): _____

For glucocorticoid-induced osteoporosis in men and women at high risk for fracture, answer the following:

Does the patient have history of taking prednisone, or its equivalent, at a dose ≥ 5 mg/day for 3 months or more? ❑ **Yes** ❑ **No**

Document the bone mineral density (BMD) T-score from the lumbar spine (at least two vertebral bodies), hip (femoral neck or total hip), or radius (one-third radius site):_____(specify if negative) Date: _____

Select if the patient has history of fractures resulting from minimal trauma including the following:
❑ Fracture of the hip ❑ Fracture of the distal radius ❑ Vertebral compression fracture

Does the patient have history of failure, contraindication, or intolerance to one bisphosphonate (e.g., alendronate)? ❑ **Yes** ❑ **No**

Has the treatment duration with parathyroid hormones [Forteo (teriparatide), Tymlos (abaloparatide)] exceeded 24 months of therapy during the patient's lifetime? ❑ **Yes** ❑ **No**

For osteoporosis in postmenopausal women or men with primary or hypogonadal osteoporosis at high risk for fracture, answer the following:

Document the bone mineral density (BMD) T-score from the lumbar spine, femoral neck, total hip, or radius (one-third radius site):

T-Score:_____(specify if negative) Date: _____

Select if the patient has history of fractures resulting from low-trauma including the following:
❑ Distal forearm ❑ Pelvis ❑ Spine
❑ Hip ❑ Proximal humerus

Does the patient have history of failure, contraindication, or intolerance to one osteoporosis treatment [e.g., alendronate, risedronate, zoledronic acid, Prolia (denosumab)]? ❑ **Yes** ❑ **No**

For osteopenia, select if the patient has the following FRAX 10-year probabilities:
❑ Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions
❑ Hip fracture is 3% or more in the U.S., or the country-specific threshold in other countries or regions

Has the treatment duration with parathyroid hormones [Forteo (teriparatide), Tymlos (abaloparatide)] exceeded 24 months of therapy during the patient's lifetime? ❑ **Yes** ❑ **No**

Reauthorization:

Is there documentation the patient has had a positive clinical response to Forteo (teriparatide) therapy? ❑ **Yes** ❑ **No**

Has the treatment duration with Forteo exceeded 24 months of therapy during the patient's lifetime? ❑ **Yes** ❑ **No**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician fe els is important to this review?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	