TRICARE Prior Authorization Request Form for
teriparatide 600 mcg (Forteo and generic)

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization expires after 24 months

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID #: _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. **The brand Forteo formulation is the preferred product over generic teriparatide and is covered at the lowest copayment, which is the generic formulary copayment for non-Active-Duty patients, and at no cost share for Active-Duty patients. (Although Forteo is a branded product, it will be covered at the generic formulary copayment or cost share) Please type "Acknowledge" and proceed to the next question.**	Proceed to question **2**	
2. **Is the patient GREATER THAN or EQUAL to 18 years of age?**	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. **Is Forteo being prescribed for treatment of osteoporosis, and not for prevention of osteoporosis?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. **Is the patient a postmenopausal female with osteoporosis?**	☐ Yes Proceed to question **7**	☐ No Proceed to question **5**
5. **Is the patient male with primary or hypogonadal osteoporosis?**	☐ Yes Proceed to question **7**	☐ No Proceed to question **6**
6. **Does the patient have osteoporosis associated with sustained systemic glucocorticoid therapy (for example, GREATER THAN 6 months use of GREATER THAN 7.5mg/day prednisone or equivalent)?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

TRICARE Prior Authorization Request Form for
teriparatide 600 mcg (Forteo and generic)

7. Is the patient at high risk for fracture defined as one of the following; history of osteoporotic fracture, multiple risk factors for fracture (for example, a history of vertebral fracture or low-trauma fragility fracture of the hip, spine or pelvis, distal forearm or proximal humerus)?	☐ Yes Proceed to question **10**	☐ No Proceed to question **8**
8. Does the patient have a bone mineral density (BMD) T-score of -2.5 or worse?	☐ Yes Proceed to question **10**	☐ No Proceed to question **9**
9. Has the patient tried and experienced an inadequate response to, therapeutic failure with, is intolerant to (unable to use or absorb), or has contraindications to at least one formulary osteoporosis therapy (for example, alendronate, ibandronate)?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Will the patient continue to take calcium and vitamin D supplementation during PTH analog therapy if dietary intake is inadequate?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Will the cumulative treatment with Forteo and Tymlos exceed 24 months during the patient's lifetime?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **12**
12. What is the requested medication?	☐ brand Forteo **Sign and date below**	☐ generic teriparatide Proceed to question **13**
13. Please provide a patient-specific justification as to why the brand Forteo cannot be used in this patient.	_____ **Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[27 Dec 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: