TRICARE Prior Authorization Request Form for
**teriparatide (Forteo)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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.

**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. Is the patient GREATER THAN or EQUAL to 18 years of age?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Is Forteo being prescribed for treatment of osteoporosis, and not for prevention of osteoporosis?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **3. Is the patient a postmenopausal female with osteoporosis?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>Proceed to question **4** |
| **4. Is the patient male with primary or hypogonadal osteoporosis?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>Proceed to question **5** |
| **5. Does the patient have osteoporosis associated with sustained systemic glucocorticoid therapy (e.g., GREATER THAN 6 months use of GREATER THAN 7.5mg/day prednisone or equivalent)?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Is the patient at high risk for fracture defined as one of the following; history of osteoporotic fracture, multiple risk factors for fracture (e.g., a history of vertebral fracture or low-trauma fragility fracture of the hip, spine or pelvis, distal forearm or proximal humerus)?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>Proceed to question **7** |

TRICARE Prior Authorization Request Form for
**teriparatide (Forteo)**

| | | |
|---|---|---|
| **7. Does the patient have a bone mineral density (BMD) T-score of -2.5 or worse?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>Proceed to question **8** |
| **8. 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 (e.g., alendronate, ibandronate)?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Will the patient continue to take calcium and vitamin D supplementation during PTH analog therapy if dietary intake is inadequate?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **10. Will the cumulative treatment with Forteo and Tymlos exceed 24 months during the patient's lifetime?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>Proceed to question **11** |
| **11. Is the patient at increased risk for osteosarcoma (e.g., Paget's disease, unexplained elevations of alkaline phosphatase, patients with open epiphyses, prior external beam or implant radiation therapy involving the skeleton)?** | ☐ Yes<br>**STOP**<br>**Coverage not approved** | ☐ No<br>**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 _____

[ 8 May 2019 ]

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