Prior Authorization Request Form for Teriparatide injection

JOHNS HOPKINS MEDICINE
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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. Forteo is the Department of Defense's preferred osteoporosis parathyroid hormone (PTH) analog. The preferred product does not require prior authorization. Please consider changing the prescription to the preferred product.	☐ Acknowledged Proceed to question **2**	
2. Has the patient tried and failed Forteo?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Is the requested medication prescribed for treatment of osteoporosis and not for prevention of osteoporosis?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. What is the indication or diagnosis?	☐ Postmenopausal female patient with osteoporosis - Proceed to question **6** ☐ Male patient with primary or hypogonadal osteoporosis - Proceed to question **6** ☐ Male or female patient with osteoporosis associated with sustained systemic glucocorticoid therapy (for example, more than 6 months use of greater than 7.5 mg/day of prednisone or equivalent) - Proceed to question **6** ☐ Other - **STOP Coverage not approved**	

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6. Does the patient have a high risk for fracture due to history of osteoporotic fracture?	☐ Yes Proceed to question **8**	☐ No Proceed to question **7**
7. Does the patient have 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 **8**	☐ No **STOP** **Coverage not approved**
8. Does the patient have a documented bone mineral density (BMD) with T-score of -2.5 or worse?	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Is the patient able to take calcium and vitamin D supplements and will continue throughout therapy?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried and experienced an inadequate response to at least one formulary osteoporosis therapy (for example, alendronate, ibandronate)?	☐ Yes Proceed to question **14**	☐ No Proceed to question **11**
11. Has the patient had therapeutic failure with at least one formulary osteoporosis therapy (for example, alendronate, ibandronate)?	☐ Yes Proceed to question **14**	☐ No Proceed to question **12**
12. Is the patient intolerant to (unable to use or absorb) to at least one formulary osteoporosis therapy (for example, alendronate, ibandronate)?	☐ Yes Proceed to question **14**	☐ No Proceed to question **13**
13. Does the patient have contraindications to at least one formulary osteoporosis therapy (for example, alendronate, ibandronate)?	☐ Yes Proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Does the patient have an increased risk for osteosarcoma?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **15**
15. Will the cumulative treatment with teriparatide/Bonsity, Tymlos, and/or Forteo exceed 24 months during the patient's lifetime?	☐ Yes **STOP** **Coverage not approved**	☐ No **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

[05 August 2020]

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