ProCare Rx

Forteo® teriparatide

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of Forteo® teriparatide. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:	Plan Name/Plan ID:		
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:	

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. Is this patient at least 18 years of age? YES NO
2. What is the patient's gender? ☐ Female ☐ Male
3. Does the patient meet any of the following? (check all that apply) YES NO
   - ☐ History of osteoporotic fracture
   - ☐ Multiple risk factors for fracture
   - ☐ Failure of previous osteoporosis therapy (Actonel, Fosamax)
   - ☐ Intolerance to previous osteoporosis therapy (Actonel, Fosamax)
4. Does patient have a history of any of the following? (check all that apply) YES NO
   - ☐ Bone metastases or history of skeletal malignancies
   - ☐ Metabolic bone diseases other than osteoporosis
   - ☐ Paget's disease of bone or unexplained elevations of alkaline phosphatase
   - ☐ Prior radiation therapy involving the skeleton
   - ☐ Pre-existing hypercalcemia (eg. Primary hyperparathyroidism)

PA Renewal Only?

1. Has patient been treated with Forteo for more than 24 months?
2. Has patient complained of persistent nausea, vomiting, constipation, lethargy or muscle weakness? YES NO

Dosing Guidelines: The recommended dosage is 20 mcg SC QD. Duration of therapy must not exceed 2 years. YES NO

Authorized Medical Signature:	
Telephone:	Date:

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.