



Forteo
(teriparatide)

Prior Authorization Form
Curascript
Fax (888) 773-7386

Last Name		First Name		Prescriber's Name		Specialty	
Home Phone		Work Phone		Office Phone		Office Fax	
Home Address		City	State	ZIP	Address		City State ZIP
SCAN ID number		Date of Birth		Est. Start Date		Office Contact	
For Specialty Medications Only: Shipping Address (if different from home address) <input type="checkbox"/> Physician <input type="checkbox"/> Home				Special Instructions (i.e. Non-English Speaking Patient, etc.):			

Medication:		Diagnosis:	
Sig:	Qty:	Refills:	ICD 9 Code:

Secondary/ Supplemental Insurance Company	Phone	Name of Insured	ID Number	Group Number
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1. Does the patient have a diagnosis of osteoporosis and at high risk for fractures (BMD T score below -2.0, steroids use) or with a history of two or more osteoporotic fractures?
2. Does the patient have increased baseline risk for osteosarcoma (Paget's disease, prior skeletal radiation therapy)
3. Did the patient have a fracture and/or a $\geq 10\%$ loss in bone density while on Actonel, Fosamax, or Evista for at least 1 year?
4. Is the patient intolerant to both Actonel and Fosamax?
5. Is the patient intolerant to either Actonel or Fosamax?
6. Was intolerance due to esophageal pain?
7. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

For Internal Use Only	
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied
Reviewer's Initials _____	Decision Date _____
Comments _____	

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.