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	
VH ID number	Date of Birth	Est. Start Date	Office Contact
For Specialty Medications Only: Shipping Address (if different from home address) ☐ Physician ☐ 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

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 ≥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? If No, continue to #5.**
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
☐ Approved ☐ 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.