

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM



Teriparatide - Medicare

Phone: 215-991-4300

Fax back to: 866-371-3239

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

**Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.**

Q1. Does the patient have a documented diagnosis of osteoporosis (glucocorticoid-induced, primary or hypogonadal in men, or postmenopausal in women)?
Please submit documentation.

Yes No

Q2. Is the patient 18 years of age or older?

Yes No

Q3. Are the following baseline labs (DXA scan, serum calcium, phosphorus, creatinine, alkaline phosphatase, albumin, 25-hydroxyvitamin D [25[OH]D]) attached?

Yes No

Q4. Has the member had an inadequate response or the inability to tolerate at least one of the following: bisphosphonates, hormone replacement therapy, or selective-estrogen receptor modulators (SERMs)?

Yes No

Q5. Requested Duration:

12 months Other

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Patient Name:	Prescriber Name:
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Q6. Additional Information:

Prescriber Signature

Date

2024 Medicare Prior Authorization Request