Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Forteo® (teriparatide)

Phone: 215-991-4300 Fax back to: 866-240-3712

Health Partners 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:**	
HPP Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Address:	NPI:	Promise ID:
City, State ZIP:	*Prescriber PA PROMISe ID:*	
Patient Primary Phone:	Address:	
Line of Business: □ Medicaid □ CHIP	City, State ZIP: Specialty/facility name (if applicable):	

□ Expedited/Urgent

Drug Name:
Strength:
Days Supply:
Number of Refills:
Directions / SIG:

HPP's maximum approval time is 12 months but may be less depending on the drug.

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. Is the patient equal to or greater than 18 years of age?

☐ Yes ☐ No

Q2. Is the patient a postmenopausal female with osteoporosis who has a high risk of fracture, which is defined as having a history of osteoporotic fracture, multiple risk factors for fracture, or are intolerant to other available osteoporosis therapy?

☐ Yes ☐ No

Q3. Is the patient a male who has primary or hypogonadal osteoporosis with a high risk of fracture, which is defined as having a history of osteoporotic fracture, multiple risk factors for fracture, or are intolerant to other available osteoporosis therapy?

☐ Yes ☐ No

Q4. Is the patient a male or female with osteoporosis associated with sustained systemic glucocorticoid therapy (at a daily dosage equivalent to 5 mg of prednisone or greater for 3 months or more) that have a high risk of fracture, which is defined as a history of osteoporotic fracture, multiple risk factors for fracture, or are intolerant to other available osteoporosis therapy?

☐ Yes ☐ No

Q5. Has the patient had counseling with regard to measures to prevent fractures, such as exercise, smoking cessation, alcohol restriction, dietary counseling, weight, environmental modification to prevent falls, measures to reduce the impact of falls?

Health Partners Plans

HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Forteo® (teriparatide)

Phone: 215-991-4300 **Fax back to: 866-240-3712**

Health Partners 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:**

☐ Yes	☐ No
Q6. Has the patient been evaluated for other causes of bone loss through laboratory tests (such as blood calcium levels, thyroid function tests, parathyroid hormone tests, testosterone levels in men, estradiol levels in women, 25-hydroxyvitamin D, complete blood count, biochemical profile)? Please submit test results.	
☐ Yes	☐ No
Q7. Has the patient tried and failed treatment with vitamin D and calcium supplements?	
☐ Yes	☐ No
Q8. Has the patient tried and failed treatment with alendronate sodium (men and women), Ibandronate (women) or Raloxifene (women only)?	
☐ Yes	☐ No
Q9. Has the patient had their bone mineral density (by DEXA scan) measured? Please submit test results.	
☐ Yes	☐ No
Q10. Does the DEXA scan results show that the patient has osteoporosis (T-score less than or equal to -2.5)?	
☐ Yes	☐ No
Q11. Requested Duration:	
☐ 12 months	
Q12. Additional Comments:	

Prescriber Signature _____ Date _____

Updated 2018