Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Forteo (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Forteo (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

FORTEO (teriparatide)

Other, Please specify: _____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has the patient received a total of 24 months of Forteo therapy? Y N

   [If yes, no further questions.]

2. Is Forteo requested for the treatment of osteoporosis in a man or a postmenopausal woman? Y N

   [If no, skip to question 8.]

3. Does the patient have a low bone density less than 2.5 SD (standard deviations) below normal (T-score -2.5 or less) OR does the patient have a fragility fracture at the hip, spine, wrist, arm, rib, or pelvis? Y N

If yes, submit records or document T-score and date:

_____

[If no, then no further questions.]

4. Is the request for a male patient? Y N

   [If no, skip to question 13.]

5. Does the patient have normal testosterone levels? Y N

   Submit labs or document result and date:

   _____

   [If yes, skip to question 13.]

6. Is the patient receiving testosterone replacement therapy? Y N

   [If yes, skip to question 13.]

7. Does the patient have a history of prostate cancer? Y N

   [If yes, skip to question 13.]

   [If no, then no further questions.]

8. Is Forteo being used for the treatment of corticosteroid-induced osteoporosis? Y N

   [If no, then no further questions.]

9. Is the request for a PREmenopausal woman or a man less than 50 years old? Y N

   [If no, then skip to question 11.]

10. Does the patient have a history of a fragility fracture? Y N

    [If yes, skip to question 12.]

    [If no, then no further questions.]

11. Is the request for a postmenopausal woman or a man 50 years of age or older? Y N

    [If no, then no further questions.

12. Has the patient received, or is expected to receive, at least 7.5mg/day of prednisone (or equivalent) for at least 3 months? Y N

[If no, then no further questions.]

13. Does the patient have a 25-hydroxyvitamin D level above 20ng/mL? Y N

    (Note: Patients who are vitamin D deficient should have vitamin D replaced before starting treatment with Forteo.)

    If yes, submit labs or document result and date:

    _____

    [If no, then no further questions.]

14. Does the patient meet ONE of the following? A) Decreased T-score after at least 2 years of compliant therapy with at least one formulary oral bisphosphonate (i.e., alendronate), B) New fracture while taking an oral bisphosphonate (i.e., alendronate), or C) Contraindication or SEVERE intolerance to oral bisphosphonates (i.e., current upper GI symptoms, inability to swallow, osteonecrosis of the jaw, or inability to remain in an upright position after oral bisphosphonate administration for the required length of time) Y N

    If yes, submit records or provide details here:

    _____

    [No further questions.]

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date