



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare) Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS) Forteo (Medicare Determination)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Forteo (Medicare Determination).

Drug Name (select from list of drugs shown)

Forteo (teriparatide)

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State,

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|--|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services? | Y | N |
| 2. Is Forteo being prescribed as a diagnostic aid for hypoparathyroidism?
[If the answer to this question is yes, then skip to question 7.] | Y | N |
| 3. Does the patient (EITHER male OR female) have the diagnosis of either primary osteoporosis or hypogonadal osteoporosis?
[If the answer to this question is no, then no further questions required.] | Y | N |
| 4. Does the patient have a history of osteoporotic fractures?
[If the answer to this question is yes, then skip to question 7.] | Y | N |
| 5. Does the patient have multiple risk factors for fractures?
[Some examples are:
-very low bone mineral density (BMD)
-frequent falls
-limited movement (e.g., using a wheelchair)
-medical condition likely to cause bone loss
-medications that may cause bone loss]
[If the answer to this question is yes, then skip to question 7.] | Y | N |



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|----|---|---|---|
| 6. | Has the patient EITHER failed OR is the patient intolerant to traditional osteoporosis therapy [e.g., hormone therapies (testosterone in men), bisphosphonates (Actonel, Fosamax, Boniva oral), SERMs (Evista), calcitonin (Miacalcin)]?
[If the answer to this question is no, then no further questions required.] | Y | N |
| 7. | Does the patient have ANY of the following contraindications to Forteo therapy?
- diagnosis of Paget's disease
- an unexplained elevation of alkaline phosphatase
- open epiphyses
- diagnosis of bone cancer or cancer that has metastasized to the bone
- prior radiation therapy involving the skeleton
- diagnosis of hypercalcemia (total serum calcium greater than 10.5 mg/dL) | Y | N |
| 8. | Has the patient been on Forteo therapy for a total of 24 months or more? | Y | N |
| 9. | Will the patient be receiving bisphosphonate therapy concurrent with Forteo therapy? | Y | N |

Comments: _____

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

Prescriber (Or Authorized) Signature and Date