

USFHP Prior Authorization Request Form for teriparatide 560 mcg (Forteo and generic)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:

Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

<https://www.usfamilyhealth.org/for-providers/pharmacy-information/>

Prior authorization expires after 24 months. Renewal approves for lifetime. For renewal of therapy, an initial Tricare prior authorization approval is required.

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete the clinical assessment:

1. Has the patient received this medication under the TRICARE benefit in the last 6 months? <i>Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.</i>	<input type="checkbox"/> Yes (subject to verification) Proceed to question 15	<input type="checkbox"/> No Proceed to question 2
2. The brand Forteo formulation is the preferred product over generic teriparatide and is covered at the lowest copayment, which is the generic formulary copayment for non-Active-Duty patients, and at no cost share for Active-Duty patients. (Although Forteo is a branded product, it will be covered at the generic formulary copayment or cost share).	<input type="checkbox"/> Acknowledged Proceed to question 3	
3. Is the patient 18 years of age or older?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is Forteo being prescribed for treatment of osteoporosis, and not for prevention of osteoporosis?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No STOP Coverage not approved
5. Is the patient a postmenopausal female with osteoporosis?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Proceed to question 6

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6. Is the patient male with primary or hypogonadal osteoporosis?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No Proceed to question 7
7. Does the patient have osteoporosis associated with sustained systemic glucocorticoid therapy (for example, GREATER THAN 6 months use of GREATER THAN 7.5mg/day prednisone or equivalent)?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No STOP Coverage not approved
8. Is the patient at high risk for fracture defined as one of the following; history of osteoporotic fracture, multiple risk factors for fracture (for example, a history of vertebral fracture or low-trauma fragility fracture of the hip, spine or pelvis, distal forearm or proximal humerus)?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Proceed to question 9
9. Does the patient have a bone mineral density (BMD) T-score of -2.5 or worse?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No Proceed to question 10
10. Has the patient tried and experienced an inadequate response to, therapeutic failure with, is intolerant to (unable to use or absorb), or has contraindications to at least one formulary osteoporosis therapy (for example, alendronate, ibandronate)?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
11. Will the patient continue to take calcium and vitamin D supplementation during PTH analog therapy if dietary intake is inadequate?	<input type="checkbox"/> Yes Proceed to question 12	<input type="checkbox"/> No STOP Coverage not approved
12. Is the patient at increased risk for osteosarcoma (for example, Paget's disease, unexplained elevations of alkaline phosphatase, patients with open epiphyses, prior external beam or implant radiation therapy involving the skeleton)?	<input type="checkbox"/> Yes STOP Coverage not approved	<input type="checkbox"/> No Proceed to question 13
13. What is the requested medication?	<input type="checkbox"/> brand Forteo Sign and date below	<input type="checkbox"/> generic teriparatide Proceed to question 14
14. Please provide a patient-specific justification as to why the brand Forteo cannot be used in this patient.	<hr style="width: 80%; margin: 0 auto;"/> Sign and date below	

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15. Has the patient had a positive response to therapy?	<input type="checkbox"/> Yes Proceed to question 16	<input type="checkbox"/> No STOP Coverage not approved
16. Does the provider acknowledge that there are limited data assessing the risk of osteosarcoma beyond 2 years of use with teriparatide?	<input type="checkbox"/> Acknowledged Sign and date below	

Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date