



Prescription Drug Coverage Determination Form
Osteoporosis
Forteo® (teriparatide)

Please fax the completed form to Mercy Health Plans' Pharmacy Department
at 314-214-8201 or 1-800-466-9854.

Patient Information

Patient Name: _____ Date of Birth: _____
Subscriber ID#: _____
Address _____ City _____ State _____ Zip Code _____

Physician Information

Name: _____ Specialty: _____ Tax ID#: _____
Office Address _____ City _____ State _____ Zip Code _____
Telephone: _____ Fax: _____ Contact Person _____

Physician Signature (REQUIRED): _____ Date _____

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: _____ J-code: _____
Dose: _____ Directions: _____
Expected Duration of Therapy: _____

Prior Authorization Criteria:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diagnosis: _____ ICD-9 code _____ | | |
| 2. Does the patient have a history of osteoporotic fractures? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Date of fracture _____ | | |
| 3. Does the patient have multiple risk factors for fractures including: | | |
| ▪ Very low bone mineral density (BMD). T-score at least 2.5 standard deviations below the mean | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Current BMD: _____ Current T-score: _____ | | |
| ▪ Female sex | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Age >60 years | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Estrogen deficiency | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Low testosterone level (men) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Cigarette smoking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Medications (corticosteroids, anticonvulsants, or thyroid medications) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| ▪ Thin or small frame (<70 kg) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

▪ Family history of osteoporosis (1 st degree relative)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Diet low in calcium	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Physical inactivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
▪ Excessive use of alcohol—only if it affects nutrition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Has the patient failed, intolerant to, or has a contraindication to traditional osteoporosis therapy [e.g. hormone therapies (testosterone in men), bisphosphonates (Actonel, Fosamax, Boniva oral), SERMs (Evista), calcitonin (Miacalcin)]?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Does the patient have a diagnosis of Paget's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does the patient have an unexplained elevation of alkaline phosphatase?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Does the patient have open epiphyses?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Has the patient been diagnosed with bone cancer or cancer that has metastasized to the bone?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Does the patient have a history of breast cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Has the patient had prior radiation therapy involving the skeleton?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. Does the patient have a diagnosis of hypercalcemia (total serum calcium >10.5 mg/dL)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
12. Has the patient been treated with Forteo® for ≥24 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
13. Has the patient received concurrent bisphosphonate therapy during treatment with Forteo®?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.