



Forteo® Prior Authorization Request Form

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information call 314-214-8282 or 800-647-2240.

Patient Name: _____

Today's Date: ____/____/____

Patient Pharmacy ID: _____
(located on bottom right of insurance card)

Date of Birth: ____/____/____

Requesting Physician: _____
(Please print)

Specialty: _____

Office Contact Person: _____

Phone #: __ (____) ____ - ____ ext ____

Medication/dose Requested: _____

Fax #: __ (____) ____ - ____

Expected Duration of Therapy: _____

ICD-9 _____

1. Gender (circle)	Male	Female		
2. Does the patient have a diagnosis of Primary osteoporosis in postmenopausal patients at high risk for fracture?			YES	NO
3. Does the patient have a diagnosis of increased bone mass in men with primary or hypogonadal osteoporosis?			YES	NO
4. Does the patient have any of the following risk factors for possible fracture? (mark all that apply)			YES	NO
History of osteoporotic fracture? Date of (or) determined date of fracture: _____				
Very low bone mineral density (BMD). T-score AT LEAST 2.5 Standard Deviations from the mean				
Current BMD: _____ Current T-score: _____				
Other risk factors for fracture				
<input type="checkbox"/> Female sex	<input type="checkbox"/>	<input type="checkbox"/> Thin or small frame (<70 kg)	<input type="checkbox"/>	
<input type="checkbox"/> Age > 60 years	<input type="checkbox"/>	<input type="checkbox"/> Family history of osteoporosis (1st degree relative)	<input type="checkbox"/>	
<input type="checkbox"/> Estrogen deficiency	<input type="checkbox"/>	<input type="checkbox"/> Diet low in calcium - for a long period of time (years)	<input type="checkbox"/>	
<input type="checkbox"/> Low testosterone levels (men)	<input type="checkbox"/>	<input type="checkbox"/> Physical inactivity	<input type="checkbox"/>	
<input type="checkbox"/> Cigarette smoking	<input type="checkbox"/>	<input type="checkbox"/> Excessive use of alcohol - only if affects nutrition	<input type="checkbox"/>	
<input type="checkbox"/> Medications (corticosteroids, anticonvulsants, or thyroid medications)	<input type="checkbox"/>			
5. Has the patient failed previous bisphosphonate therapy?			YES	NO
Medication(s) tried: _____				
Length of trial? _____				
6. Has a fracture occurred while on bisphosphonate?			YES	NO
7. Has the patient experience at least 10% loss in bone density while on a bisphosphonate?			YES	NO
8. Does the patient have any of the following? (mark all that apply)			YES	NO
<input type="checkbox"/> An increased risk of osteosarcoma	<input type="checkbox"/>	<input type="checkbox"/> History if skeletal metastases		
<input type="checkbox"/> History of hyperparathyroidism	<input type="checkbox"/>	<input type="checkbox"/> Hypercalcemia		
<input type="checkbox"/> Metabolic bone disease other than osteoporosis	<input type="checkbox"/>			

Physician's Signature: _____

Date: ____/____/____

For Mercy Health Plans use only:	Approved	Length of Approval _____
Denied	Reason for Denial _____	
Reviewer's Signature: _____	Date Reviewed: ____/____/____	
Override Entered in Caremark CCMS for _____	- _____	by _____
Office Notified on _____	at _____	am/pm by _____