



Prescription Drug Coverage Determination Form
Osteoporosis
Forteo® (teriparatide)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-647-2240.

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. Does the patient (male or female) have a diagnosis of either primary osteoporosis (e.g. postmenopausal osteoporosis in women) or hypogonadal osteoporosis?
2. Does the patient have a history of osteoporotic fractures?
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
- Female sex
- Age >60 years
- Estrogen deficiency
- Low testosterone level (men)
- Cigarette smoking
- Medications (corticosteroids, anticonvulsants, or thyroid medications)
- Thin or small frame (<70 kg)
- Family history of osteoporosis (1st degree relative)

| | | |
|--|------------------------------|-----------------------------|
| ▪ 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 |
| 3. 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 |
| 4. Does the patient have a diagnosis of Paget's disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Does the patient have an unexplained elevation of alkaline phosphatase? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Does the patient have open epiphyses? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Has the patient been diagnosed with bone cancer or cancer that has metastasized to the bone? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Does the patient have a history of breast cancer? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Has the patient had prior radiation therapy involving the skeleton? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Does the patient have a diagnosis of hypercalcemia (total serum calcium >10.5 mg/dL)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 11. Has the patient been treated with Forteo® for ≥24 months? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 12. 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.