

# Forteo (Teriparatide) Prior Authorization Form



**START HERE**

**Member & Prescriber Information**

Member Name:	Prescriber Name:
	Prescriber Specialty:
Member Date of Birth:	Prescriber Phone #:
Member ID #:	Prescriber Fax #:

**Criteria**

Forteo must be prescribed by an endocrinologist or rheumatologist:

BMD T-score below -2.5 by DEXA for lumbar spine, femoral neck, trochanter, and/or total hip.

or

BMD T-score below -1 by DEXA in patients with vertebral fracture.

or

Sustained systemic glucocorticoid therapy.

Initial approval duration is 2 years.

**Diagnosis:**

**Fracture History** (list all vertebral and non-traumatic fracture locations/dates)

Fracture location (include number)	Date

**BMD testing history** (must list at least 2 test results)

Date/Anatomic Location	T-Score Result

**Prior therapies required** (provide dates and reason for stopping)

<input type="checkbox"/> Alendronate (Date: _____ ) Reason: _____	<input type="checkbox"/> Residronate (Date: _____ ) Reason: _____
<input type="checkbox"/> Ibandronate (Date: _____ ) Reason: _____	<input type="checkbox"/> Zoledronate (Date: _____ ) Reason: _____

**Choose Product**

**Forteo** 600 mcg/2.4ml (One pre-filled pen device lasts 28 days.AWP: \$996.50)

**Sign/Date & Mail or Fax**

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Prescriber NPI: \_\_\_\_\_

**Mailing Address**  
Physicians Plus Insurance Corporation  
Attn: Pharmacy Services  
P.O. Box 2078  
Madison WI 53701-2078

**Physicians Plus Pharmacy Services Fax:**  
(608) 258-1905  
**Prior Authorization Questions?**  
(608) 260-7803 or (800) 545-5015 (ext. 7803)  
www.pplusic.com/providers