

**Physician's Prior Authorization Questionnaire
Forteo®**

Patient:

ID#:

DOB:

Patient Address:

Forteo® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? (*Please check one.*) Osteopenia Osteoporosis Other
2. What is the patient's current bone mineral density (BMD) T-score measurement from the hip or spine?
_____ Date of test: _____
3. Is the patient postmenopausal? Yes No Not Applicable
4. Has the patient taken chronic glucocorticoids (equivalent to 5 mg of prednisone daily) for at least 3 consecutive months? Yes No Not Applicable
5. Does the patient have a previous osteoporosis related fragility or low trauma fracture? Yes No
6. Has the patient received previous osteoporosis therapy? Yes No

If yes, has the patient's disease progressed despite treatment with previous therapy for at least one year (evidenced by progressing T-score or emergence of new fractures)? Yes No

Baseline BMD T-score: _____ Date of test: _____

Please list the previous therapy: _____

7. Will Forteo® be used in combination with other osteoporosis related medications (other than calcium and vitamin D)? Yes No

Forteo® will be shipped to the patient from our Specialty Pharmacy vendor.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx