



Forteo® Prior Authorization Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For additional information call 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
 Patient Pharmacy ID: _____ Date of Birth: ____/____/____
(located on bottom right of insurance card)
 Requesting Physician: _____ Specialty: _____
(Please print)
 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
<input type="checkbox"/> History of osteoporotic fracture? Date of (or) determined date of fracture: _____				
<input type="checkbox"/> Very low bone mineral density (BMD). T-score AT LEAST 2.5 Standard Deviations from the mean Current BMD: _____ Current T-score: _____				
<input type="checkbox"/> Other risk factors for fracture				
_____ Female sex		_____ Thin or small frame (<70 kg)		
_____ Age > 60 years		_____ Family history of osteoporosis (1st degree relative)		
_____ Estrogen deficiency		_____ Diet low in calcium - for a long period of time (years)		
_____ Low testosterone levels (men)		_____ Physical inactivity		
_____ Cigarette smoking		_____ Excessive use of alcohol - only if affects nutrition		
_____ Medications (corticosteroids, anticonvulsants, or thyroid medications)				
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
_____ An increased risk of osteosarcoma		_____ History of skeletal metastases		
_____ History of hyperparathyroidism		_____ Hypercalcemia		
_____ Metabolic bone disease other than osteoporosis				

Physician's Signature: _____ Date: ____/____/____

For Mercy Health Plans use only:	<input type="checkbox"/> Approved	Length of Approval _____
<input type="checkbox"/> Denied	Reason for Denial _____	
Reviewer's Signature: _____	Date Reviewed: ____/____/____	
Override Entered in <input type="checkbox"/> Caremark <input type="checkbox"/> CCMS for _____	- _____	by _____
Office Notified on _____	; at _____ am/pm;	by _____ spoke to _____