

**Forteo® (teriparatide) PreDetermination of Medical Benefits**  
Complete form in its entirety and fax to UM Call Center at (404) 848-2448

Click on grey boxes to type

Request Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

- Initial Authorization Request       Re-Authorization Request; List Prior Auth Ref #: \_\_\_\_\_
- Medication(s) is to be dispensed, delivered, and managed by PrecisionRx Specialty Solutions (800.870.6419)       Yes     No

| 1. PATIENT INFORMATION   |                    |                       |                               |
|--------------------------|--------------------|-----------------------|-------------------------------|
| Patient Last Name        | Patient First Name | Patient ID Number     | Patient DOB<br>/ /            |
| Address                  | City               | State / Zip Code<br>/ | Contact Phone Number<br>( ) - |
| Date of Diagnosis<br>/ / | Primary Diagnosis  | ICD-9 Code(s)         | Patient's Current Weight      |

| 2. PHYSICIAN INFORMATION     |                            |                             |                     |
|------------------------------|----------------------------|-----------------------------|---------------------|
| Physician Last Name          | Physician First Name       | Physician DEA or NPI Number | Physician Tax ID    |
| Address                      | City                       | State                       | Zip Code            |
| Office Phone Number<br>( ) - | Office Fax Number<br>( ) - | Office Contact Name         | Physician Specialty |

| 3. MEDICATION INFORMATION – This section serves as the active prescription – signature required.                                           |                                      |                          |                   |
|--------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------|--------------------------|-------------------|
| Drug Name<br><b>Forteo</b>                                                                                                                 | HCPCS or CPT Code(s)<br><b>J3110</b> | Strength / Dose          |                   |
| Direction for Use (SIG)                                                                                                                    |                                      |                          |                   |
| Date patient is scheduled to be treated (need by date)<br>/ /                                                                              | Service From Date<br>/ /             | Service Thru Date<br>/ / | Number of Refills |
| Place of Service<br><input type="checkbox"/> MD Office <input type="checkbox"/> Pt's Home <input type="checkbox"/> Other: (please specify) |                                      |                          |                   |
| Prescriber Signature                                                                                                                       |                                      |                          | Date<br>/ /       |

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**4. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

NOTE: **To avoid delays**, please complete this form in its entirety. Incomplete forms that are missing pertinent information will be pended. If indicated, please provide **ALL** supporting lab results, progress notes, etc.

**(1) Osteoporosis**

- Yes  No Is pt postmenopausal with osteoporosis and is at high risk for fracture?
- Yes  No Is pt male with primary or hypogonadal osteoporosis and is at high risk for fracture?
- Yes  No Does pt have Paget's disease of bone?
- Yes  No Does pt have open epiphyses?
- Yes  No Does pt have prior external beam or implant radiation therapy involving the skeleton?

**(2) Other Use(s)** (This will not be reviewed unless all supporting evidence/documentation, labs, etc., are attached.)

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**5. PHYSICIAN SIGNATURE**

|  |     |
|--|-----|
|  | / / |
|--|-----|

**Prescriber Signature**

**Date**

Prior Authorization is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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**Medical Policy Reference can be found at:** [www.bcbsga.com](http://www.bcbsga.com)

Anthem UM Services, Inc. an independent company and is the licensed utilization review agent that performs utilization management services on behalf of your health benefit plan or the administrator of your health benefit plan.