OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Forteo® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Glucocorticoid-induced osteoporosis in men and women at high risk for fracture
❑ Osteoporosis– To increase bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture
❑ Osteoporosis– For postmenopausal women at high risk for fracture
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Document the bone mineral density (BMD) T-score from the lumbar spine, femoral neck, total hip, or radius (one-third radius site):
T-Score: _____ (specify if negative) Date: _____

Has the treatment duration with parathyroid hormones [Forteo (teriparatide), Tymlos (abaloparatide)] exceeded 24 months of therapy during the patient's lifetime? ❑ **Yes** ❑ **No**

Please document the number of months of parathyroid hormone therapy the patient has used in his/her lifetime: _____ months

Select if the patient has the following FRAX (Fracture Risk Assessment Tool) 10-year probabilities:
❑ Major osteoporotic fracture at 20% or more in the U.S., or the country-specific threshold in other countries or regions
❑ Hip fracture at 3% or more in the U.S., or the country-specific threshold in other countries or regions

For glucocorticoid-induced osteoporosis in men and women at high risk for fracture, also answer the following:

Does the patient have history of taking prednisone, or its equivalent, at a dose ≥ 5 mg/day for 3 months or more? ❑ **Yes** ❑ **No**

Select if the patient has history of fractures resulting from minimal trauma including the following:
❑ Fracture of the hip ❑ Fracture of the distal radius ❑ Fracture of the pelvis
❑ Fracture of the proximal humerus ❑ Vertebral compression fracture

Has the patient had trial and failure, contraindication, or intolerance to one bisphosphonate (e.g., alendronate)? ❑ **Yes** ❑ **No**

For osteoporosis in postmenopausal women or men with primary or hypogonadal osteoporosis at high risk for fracture, also answer the following:

Select if the patient has one of the following diagnosis:
❑ Postmenopausal osteoporosis or osteopenia
❑ Primary or hypogonadal osteoporosis or osteopenia

Select if the patient has history of fractures resulting from low-trauma including the following:
❑ Distal forearm ❑ Hip ❑ Pelvis ❑ Proximal humerus ❑ Spine

Has the patient had trial and failure, contraindication, or intolerance to one osteoporosis treatment [e.g., alendronate, risedronate, zoledronic acid, Prolia (denosumab)]? ❑ **Yes** ❑ **No**

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Forteo® Prior Authorization Request Form (Page 2 of 2)

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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