Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Forteo (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Forteo (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Forteo (teriparatide)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has the member received a total of 24 months of therapy with Forteo and Tymlos? Y N

   [If yes, no further questions.]

2. Is Forteo requested for the treatment of osteoporosis in a man or a postmenopausal woman? Y N

   [If no, skip to question 8.]

3. Does the member have a low bone density less than 2.5 SD (standard deviations) below normal (T-score less than -2.5) OR does the member have a fragility fracture at the hip, spine, wrist, arm, rib, or pelvis? Y N

If yes, submit records or document T-score and date: _____ Y N

[If no, then no further questions.]

4. Is the request for a male member? Y N

   [If no, skip to question 13.]

5. Does the member have normal testosterone levels for the lab reference range? Y N

   Submit labs or document result and date:
   _____

   [If yes, skip to question 14.]

6. Is the member receiving testosterone replacement therapy? Y N

   [If yes, skip to question 14.]

7. Does the member have a history of prostate cancer? Y N

   [If yes, skip to question 14.]

   [If no, then no further questions.]

8. Is Forteo being used for the treatment of glucocorticoid-induced osteoporosis? Y N

   [If no, then no further questions.]

9. Is the request for a PREmenopausal woman or a man less than 50 years old? Y N

   [If no, then skip to question 11.]

10. Does the member have a history of a fragility fracture? Y N

    [If yes, skip to question 12.]

    [If no, then no further questions.]

11. Is the request for a postmenopausal woman or a man 50 years of age or older? Y N

    [If no, then no further questions.]

12. Has the member received, or is expected to receive, over 7.5mg/day of prednisone (or equivalent) for greater than 3 months? Y N

    [If yes, skip to question 14.]

[If no, then no further questions.]

13. Has the patient had a trial and failure of the preferred agent, Tymlos? Y N

[If no, then no further questions.]

14. Does the member meet ONE of the following? A) Reduction in bone mineral density (BMD) per recent DEXA scan after at least 2 years of compliant therapy with an oral or intravenous (IV) bisphosphonate, B) New fracture while taking an oral or IV bisphosphonate, or C) Contraindication or SEVERE intolerance to oral bisphosphonates (e.g., current upper GI symptoms, inability to swallow, or inability to remain in an upright position after oral bisphosphonate administration for the required length of time) Y N

If yes, submit records or provide details here: Y N

_____

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**