PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Medicare Part D - Forteo & Tymlos

Phone: 800-728-7947 **Fax back to: 866-880-4532**

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. For what indication is this drug being prescribed (pick one)?

☐ Osteoporosis ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Please select which of the following that apply to the patient.

☐ Postmenopausal woman
☐ Man with primary or hypogonadal osteoporosis
☐ Man or woman with osteoporosis associated with sustained systemic glucocorticoid therapy

Q4. Is the patient at high risk for fracture defined as having low bone density with a T-score of less than -2.5?

☐ Yes ☐ No

Q5. Is the patient at high risk for fracture defined as history of previous osteoporosis-related fracture?

☐ Yes ☐ No

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Q6. Has the patient experienced failure of oral bisphosphonate therapy defined as new fractures while on oral bisphosphonate therapy?

☐ Yes ☐ No

Q7. Does the patient have a contraindication or intolerance to oral bisphosphonates. Intolerance includes, but not limited to, abdominal pain, constipation, diarrhea, dyspepsia, headache, musculoskeletal pain, esophagitis, or other esophageal lesions? [Please Explain]

☐ Yes ☐ No

Q8. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to a SWHP pharmacist or medical director at 1-800-728-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.