PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

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. Is the patient a new start to therapy?

☐ Yes ☐ No (please provide start date)

Q2. For what indication is this drug being prescribed (pick one)?

☐ Osteoporosis ☐ Other

Q3. Please provide ICD code(s) for diagnosis.

Q4. Is this initial osteoporosis therapy for this patient?

☐ Yes ☐ No

Q5. If initial therapy, does the patient have osteoporotic fractures AND a T-score of less than -3.0 in the spine, femoral neck, or total hip?

☐ Yes ☐ No

Q6. If second-line therapy, has the patient failed oral bisphosphonate therapy?

☐ Yes ☐ No

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Q7. If second-line therapy, has the patient had a bone mineral density decrease while on oral bisphosphonate therapy that is significantly greater than the least significant change for the densitometer utilized (i.e. decrease in T-score while on bisphosphonate therapy)?

☐ Yes ☐ No

Q8. If second-line therapy, has the patient experienced new fractures while on oral bisphosphonate therapy?

☐ Yes ☐ No

Q9. If second-line therapy, is the patient intolerant to oral bisphosphonates including, but not limited to, abdominal pain, constipation, diarrhea, dyspepsia, headache, musculoskeletal pain, esophagitis, or other esophageal lesions?

☐ Yes ☐ No

Q10. Who is the ENTITY that will be submitting the CLAIM for the DRUG and seeking reimbursement?

☐ Pharmacy
☐ Individual prescriber
☐ Provider or specialty group
☐ Facility
☐ Other (please specify)

Q11. Provide name and NPI of the billing entity

Q12. Will the claim for the drug be submitted as a MEDICAL claim or PHARMACY claim (Note: If a pharmacy will be submitting a MEDICAL claim for drug reimbursement, answer MEDICAL)?

☐ Medical ☐ Pharmacy

Q13. Additional Comments

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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.