Forteo (for Maryland only)

Prior Authorization Request

Send completed form to: Case Review Unit CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the indication?
   - ❑ Postmenopausal osteoporosis
   - ❑ Primary (idiopathic) or hypogonadal osteoporosis
   - ❑ Glucocorticoid-induced osteoporosis
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)*** ❑ Yes ❑ No
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. Is the patient currently on Forteo therapy **OR** has the patient received Forteo in the past? ❑ Yes ❑ No *If No, skip to diagnosis section*
7. How many months of Forteo therapy has the patient received **in their lifetime**? _____ months

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Postmenopausal Osteoporosis

8. Does the patient have a history of fragility fractures? *If Yes, no further questions* ❑ Yes ❑ No
9. Does the patient have any indicators of higher fracture risk? ❑ Yes, ***indicate and skip to #11:*** _____ ❑ No
10. Has the patient failed prior treatment with or is intolerant to previous osteoporosis therapy (i.e., oral bisphosphonates or injectable antiresorptive agents)? ❑ Yes ❑ No
11. What is the patient's pre-treatment T-score? _____ ❑ Unknown ***If less than or equal to -2.5 (ex. -3, -4), no further questions.***

12. What is the patient's pre-treatment FRAX score for any major fracture*? _____ % ❑ Unknown
**Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

13. What is the patient's pre-treatment FRAX score for hip fracture*? _____ % ❑ Unknown
**Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

Section B: Glucocorticoid-Induced Osteoporosis, Primary (Idiopathic) or Hypogonadal Osteoporosis

14. *If diagnosis is primary (idiopathic) or hypogonadal osteoporosis,* does the patient have a history of an osteoporotic vertebral or hip fracture? *If Yes, no further questions* ❑ Yes ❑ No, *skip to #19*

15. Has the patient had at least a 1-year trial of an oral bisphosphonate?
❑ Yes, ***indicate:*** _____ ❑ No

16. *If patient has not had at least a 1-year trial of an oral bisphosphonate,* is there a clinical reason to avoid treatment with an oral bisphosphonate? ***Indicate below or mark "None of the above"***
❑ Esophageal abnormality that delays emptying such as stricture or achalasia
❑ Active upper gastrointestinal problem (eg, dysphagia, gastritis, duodenitis, erosive esophagitis, ulcers)
❑ Inability to stand or sit upright for 30 to 60 minutes
❑ Inability to take oral bisphosphonate at least 30 to 60 minutes before first food, drink or medication of the day
❑ Renal insufficiency (creatinine clearance less than 30 ml/min)
❑ Other _____
❑ None of the above

17. Is the patient currently receiving or will be initiating glucocorticoid therapy? ❑ Yes ❑ No

18. Does the patient have a history of a fragility fracture? *If Yes, no further questions* ❑ Yes ❑ No

19. What is the patient's pre-treatment T-score? _____ ❑ Unknown
If less than or equal to -2.5 (ex. -3, -4), no further questions.

20. What is the patient's pre-treatment FRAX score for any major fracture*? _____ % ❑ Unknown
**Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

21. What is the patient's pre-treatment FRAX score for hip fracture*? _____ % ❑ Unknown
**Calculator available at http://www.shef.ac.uk/FRAX/tool.jsp*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**