Forteo

Prior Authorization Request

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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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? _____

Section A: All Requests

3. What is the patient's pre-treatment T-score? *Please provide the patient's T-score prior to initiation of osteoporosis treatment.* ***ACTION REQUIRED: Attach supporting chart note(s)***. _____ ❑ Unknown
   If less than or equal to -2.5 (ex. -3, -4), skip to #6.

4. What is the patient's pre-treatment FRAX score for any major fracture? (See Appendix). *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment.* ***ACTION REQUIRED: Attach supporting chart note(s)***. _____ % ❑ Unknown *If greater than or equal to 20%, skip to #6*

5. What is the patient's pre-treatment FRAX score for hip fracture? (See Appendix). *Please provide the patient's FRAX score prior to initiation of osteoporosis treatment.* ***ACTION REQUIRED: Attach supporting chart note(s)***. _____ % ❑ Unknown

6. Has the patient had at least a 1-year trial of an oral bisphosphonate? *If Yes, skip to #8* ❑ Yes ❑ No

7. Is there a clinical reason to avoid treatment with an oral bisphosphonate? ❑ Yes ❑ No
   If Yes, please indicate reason: _____

8. How many months of cumulative parathyroid hormone analogs (such as Forteo or Tymlos) therapy has the patient received in their lifetime? _____ months

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

Section B: Postmenopausal Osteoporosis

9. Does the patient have a history of fragility fractures? ***ACTION REQUIRED: If Yes, attach supporting chart note(s) and no further questions.*** ❑ Yes ❑ No

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10. Has the patient failed prior treatment with or is intolerant to previous injectable osteoporosis therapy (i.e., zoledronic acid [Reclast], denosumab [Prolia])? *If Yes, no further questions.* ❑ Yes ❑ No

11. Does the patient have any indicators of higher fracture risk (e.g., advanced age, frailty, glucocorticoid use, very low T-scores [less than or equal to -3.5], increased fall risk)? ❑ Yes ❑ No

Section C: Primary (Idiopathic) or Hypogonadal Osteoporosis

12. Does the patient have a history of an osteoporotic vertebral or hip fracture? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

Section D: Glucocorticoid-Induced Osteoporosis

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

14. Does the patient have a history of a fragility fracture? ***ACTION REQUIRED: If Yes, attach supporting chart note(s).*** ❑ Yes ❑ No

State Step Therapy

1. Is the requested drug being used for an FDA-approved indication or an indication supported in the compendia of current literature (examples: AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

2. Does the prescribed quantity fall within the manufacturer's published dosing guidelines or within dosing guidelines found in the compendia of current literature (examples: package insert, AHFS, Lexicomp, Clinical Pharmacology, Micromedex, current accepted guidelines)? ❑ Yes ❑ No

3. Does the patient reside in Maryland? ❑ Yes ❑ No *If No, skip to #7*

4. Is the alternate drug (Norditropin) FDA-approved for the medical condition being treated? ❑ Yes ❑ No

5. Has the prescriber provided proof, documented in the patient's chart notes, indicating that the requested drug was ordered for the patient in the past 180 days? ❑ Yes ❑ No *If No, skip to #7*

6. Has the prescriber provided proof, documented in the patient chart notes, that in their opinion the requested drug is effective for the patient's condition? ❑ Yes ❑ No *No further questions*

7. Are any of the following conditions met for the alternate drug (Norditropin)?
   ❑ The alternate drug is contraindicated
   ❑ The alternate drug is likely to cause an adverse reaction, physical or mental harm
   ❑ The alternate drug is expected to be ineffective
   ❑ The alternate drug was previously tried or a drug in the same class or with the same action was previously tried and was stopped due to ineffectiveness or an adverse event
   ❑ The alternate drug is not in the patient's best interest
   ❑ The alternate drug was tried while covered by the current or the previous health benefit plan
   ❑ None of the above

8. Is the patient stable or currently receiving a positive therapeutic outcome with the requested drug and a change in the prescription drug is expected to be ineffective or cause harm to the patient? ❑ Yes ❑ No

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)**

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