UnitedHealthcare
Community Plan

Forteo
PRIOR AUTHORIZATION REQUEST FORM

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form contains multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication ☐ New or ☐ Continuation of Therapy? If continuation, list start date: ________________
Is this patient currently hospitalized? ☐ Yes ☐ No If recently discharged, list discharge date: ________________

Section B - Physician Information				
First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information	
Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**
Is this member pregnant? ☐ Yes ☐ No **If yes, what is this member's due date?** ________________	

Section D – Previous Medication Trials

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs
Please refer to www.uhccommunityplan.com for a list of preferred alternatives

☐ ***Does the prescriber attest to the following: the information provided is true and accurate to the best of their knowledge and they understand that UnitedHealthcare may perform a routine audit and request the medical information necessary to verify the accuracy of the information provided.***

UnitedHealthcare Community Plan

Forteo
PRIOR AUTHORIZATION REQUEST FORM

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

All Requests:

- **What is the patient's diagnosis? (Check which applies)**
  □ Osteoporosis □ Glucocorticoid-Induced Osteoporosis
  □ Other. **List diagnosis**: ____________________________

- **Does the patient have a history of one of the following resulting from minimal trauma: □ Yes □ No**
  □ Vertebral compression fracture □ Fracture of the hip
  □ Fracture of the distal radius □ Fracture of the pelvis
  □ Fracture of the proximal humerus

- **Does the patient have a history of failure, contraindication, or intolerance to any of the following: □ Yes □ No**
  □ One conventional osteoporosis therapy [e.g., bisphosphonate or selective estrogen receptor modulator [SERM]
  □ If the request is for a post-menopausal patient, history of failure, contraindication, or intolerance to Tymlos
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **List patient's BMD-T score: ____________**

Requests for Osteoporosis:

- **Does the patient have one of the following FRAX 10-year probabilities: □ Yes □ No**
  □ Major osteoporotic fracture at 20% or more □ Hip fracture at 3% or more

Requests for Glucocorticoid-Induced Osteoporosis:

- **Does the patient have a history of prednisone or its equivalent at a dose ≥ 5mg/day for ≥ 3 months? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for Quantity Limit:

- **Has the treatment duration exceeded a total of 24 months of cumulative use of parathyroid hormone analogs (e.g., Forteo, Tymlos) during the patient's lifetime? □ Yes □ No**
  If yes, list how many months patient has already received of parathyroid hormone analogs: ______________________
  ____

Physician Signature: ____ **Date:** ___________________

Confidentiality Notice: This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.

Website: uhccommunityplan.com