aetna®

Forteo® (teriparatide) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Please indicate: ☐ Start of treatment: Start date ____/____/____ ☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: _____ Phone: _____ Fax: _____

A. PATIENT INFORMATION

First Name:	Last Name:		
Address:	City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	
DOB:	Allergies:	Email:	

Current Weight: _____ lbs or _____ kgs Height: _____ inches or _____ cms

B. INSURANCE INFORMATION

Aetna Member ID #: _____ Does patient have other coverage? ☐ Yes ☐ No

Group #: _____ If yes, provide ID#: _____ Carrier Name: _____

Insured: _____ Insured: _____

Medicare: ☐ Yes ☐ No If yes, provide ID #: _____ **Medicaid**: ☐ Yes ☐ No If yes, provide ID #: _____

C. PRESCRIBER INFORMATION

First Name:		Last Name: *(Check One):* ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.			
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider Email:		Office Contact Name:		Phone:	

Specialty *(Check one):* ☐ **GYN** ☐ **Orthopedic** ☐ **Primary Provider** ☐ **Other**: _____

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: _____
Center Name: _____
☐ Home Infusion Center Phone: _____
Agency Name: _____
☐ Administration code(s) (CPT): _____
Address: _____

Dispensing Provider/Pharmacy: *(Patient selected choice)*
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for: ☐ **Forteo** Dose: _____ Frequency: _____

F. DIAGNOSIS INFORMATION

Primary ICD Code: _____ Other ICD Code: _____

G. CLINICAL INFORMATION

For All Requests: (Supporting clinical documentation required for all requests)

Please provide the patient's Bone Mineral Density (BMD) score and date obtained: T-score: _____ Date: ____/____/____

☐ Yes ☐ No Is the patient at high risk for fractures?
→ ***Select all that apply***: ☐ History of osteoporotic fractures ☐ Failed previous osteoporosis therapy ☐ Multiple risk factors for fracture*
☐ Intolerant to previous osteoporosis therapy ☐ Other: Please explain: _____
Risk factors for fractures include history of hip fracture, rheumatoid arthritis, alcohol use of 4 or more units per day, or current tobacco use

☐ Yes ☐ No Does the patient exhibit any of the following contraindications to teriparatide (Forteo)? (***Select from list below***)
→ ☐ Current or previous history of skeletal malignancies ☐ Paget's disease or an unexplained increase in alkaline phosphatase
☐ Pre-existing hypercalcemia ☐ Hyperparathyroidism ☐ Hypersensitivity to teriparatide or any of its excipients
☐ Metabolic bone disease other than osteoporosis ☐ Osteopenia ☐ Pregnancy ☐ Lactation ☐ Prior radiation treatment

Please indicate how long the patient has received cumulative therapy with teriparatide (Forteo) and other parathyroid hormone analogs (e.g.Tymlos (abaloparatide): (in months): _____ Please provide the treatment start date: ____/____/____

For Initiation Requests:

Male primary or hypogonadal osteoporosis

Which of the following documented osteoporosis diagnoses does the patient have? ☐ Primary osteoporosis ☐ Hypogonadal osteoporosis

Please select which of the following bisphosphonates the patient tried:
→ ***Select all that apply:*** ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (etidronate)
☐ Boniva (ibandronate) ☐ Actonel or Actonel with Calcium (risedronate) ☐ Skelid (tiludronate) ☐ Zometa/Reclast (zoledronic acid)
☐ Other: please identify: _____
Bisphosphonate #1 Date range: ____/____/____ to ____/____/____
Bisphosphonate #2 Date range: ____/____/____ to ____/____/____

☐ Yes ☐ No Was the treatment with two bisphosphonates ineffective?
→ Please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____

☐ Yes ☐ No Was the treatment with two bisphosphonates not tolerated?

☐ Yes ☐ No Is the treatment with bisphosphonates contraindicated?

Continued on next page

aetna®

Forteo® (teriparatide) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
Phone: 1-855-240-0535
FAX: 1-877-269-9916

For Medicare Advantage Part B:
FAX: 1-844-268-7263

Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION *(CONTINUED)* – Required clinical information must be completed in its entirety for all precertification requests.

Post-menopausal female osteoporosis

☐ Yes ☐ No Does the patient have documented trial of two bisphosphonates?

→ Please select which of the following bisphosphonates the patient tried:

Select all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (etidronate)
☐ Boniva (ibandronate) ☐ Actonel or Actonel with Calcium (risedronate) ☐ Skelid (tiludronate) ☐ Zometa/Reclast (zoledronic acid)
☐ Other: please identify: _____

Bisphosphonate #1 Date range: ___/___/___ to ___/___/___
Bisphosphonate #2 Date range: ___/___/___ to ___/___/___

☐ Yes ☐ No Was the treatment with two bisphosphonates ineffective?

→ Please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____

☐ Yes ☐ No Was the treatment with two bisphosphonates not tolerated?
☐ Yes ☐ No Is the treatment with bisphosphonates contraindicated?

☐ Yes ☐ No Does the patient have documented trial of one bisphosphonate and one selective estrogen receptor modulator (SERM)?

→ Please select which of the following bisphosphonates and selective estrogen receptor modulator (SERM) the patient tried:

Select all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (etidronate) ☐ Evista (raloxifene) Fareston (toremifene)
☐ Boniva (ibandronate) ☐ Actonel or Actonel with Calcium (risedronate) ☐ Skelid (tiludronate) ☐ Zometa/Reclast (zoledronic acid)
☐ Soltamox (tamoxifen) ☐ Other: please identify: _____

Bisphosphonate Date range: ___/___/___ to ___/___/___
SERM Date range: ___/___/___ to ___/___/___

☐ Yes ☐ No Was the treatment with one bisphosphonates and one selective estrogen receptor modulator (SERM) ineffective?

→ Please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____

☐ Yes ☐ No Was the treatment with one bisphosphonates and one selective estrogen receptor modulator (SERM) not tolerated?
☐ Yes ☐ No Is the treatment with bisphosphonates and selective estrogen receptor modulator (SERM) contraindicated?

☐ Yes ☐ No Was the treatment with abaloparatide (Tymlos) ineffective?

→ Please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____

☐ Yes ☐ No Was the treatment with abaloparatide (Tymlos) not tolerated?

Please provide the date range of abaloparatide (Tymlos) treatment: ___/___/___ to ___/___/___

Glucocorticoid-induced osteoporosis

☐ Yes ☐ No Is the patient being treated with sustained long-term glucocorticoid therapy?

→ Please indicate the daily dose of prednisone (or its equivalent) in mg: _____

What is the length of the glucocorticoid therapy? Date range: ___/___/___ to ___/___/___

Please select which of the following bisphosphonates the patient tried:

Select all that apply: ☐ Fosamax or Fosamax plus D (alendronate) ☐ Didronel (etidronate)
☐ Boniva (ibandronate) ☐ Actonel or Actonel with Calcium (risedronate) ☐ Skelid (tiludronate) ☐ Zometa/Reclast (zoledronic acid)
☐ Other: please identify: _____

Bisphosphonate #1 Date range: ___/___/___ to ___/___/___
Bisphosphonate #2 Date range: ___/___/___ to ___/___/___

☐ Yes ☐ No Was the treatment with two bisphosphonates ineffective?

→ Please identify the failure of the medication trial: ☐ Continued bone loss ☐ Other: please identify: _____

☐ Yes ☐ No Was the treatment with two bisphosphonates not tolerated?
☐ Yes ☐ No Is the treatment with bisphosphonates contraindicated?

For Continuation requests:

☐ Yes ☐ No Is this continuation request a result of the patient receiving samples of teriparatide Forteo)? (Sampling of teriparatide Forteo) does not guarantee coverage under the provisions of the pharmacy benefit)

Please indicate which diagnosis the teriparatide (Forteo) patient is being treated for:

Select diagnosis: ☐ Post-menopausal female osteoporosis ☐ Male primary osteoporosis ☐ Male hypogonadal osteoporosis
☐ Adults with glucocorticoid-induced osteoporosis ☐ Other, identify: _____

H. ACKNOWLEDGEMENT

Request Completed By *(Signature Required):* _____ **Date:** ___/___/___

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.