

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

FORTEO (teriparatide)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF

MEDICAL NECESSITY TO 855-828-4992

CRITERIA:

- Available for the following diagnoses at high risk for bone fracture:
 - Postmenopausal women diagnosed with osteoporosis.
 - Women and men diagnosed with osteoporosis likely caused by systemic glucocorticoid therapy.
 - Men diagnosed with osteoporosis (primary or hypogonadal).
- Quantity limit of one injector every 28 days.

AUTHORIZATION:

24 months with no renewal option.

9/13/10