



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

FORTEO (Teriparatide)

Indications for Coverage

Primary Osteoporosis or Hypogonadal Osteoporosis - patient must have at least one of the following: history of osteoporotic fractures, multiple risk factors for fractures or patient has failed or is intolerant to traditional osteoporosis therapy

Exclusion Criteria

Duration of therapy in excess of 24 months; concurrent bisphosphonate therapy; Paget's disease; hypercalcemia; open epiphyses; bone cancer or cancer that has metastasized to the bone; history of breast cancer; prior radiation therapy involving the skeleton

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

FORTEO	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage
Please List Alternative Formulary Drugs	

Comments	
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Physicians Signature: _____ Fax Form to 1-877-847-9904