

FORTEO®
PRIOR AUTHORIZATION
Physician Fax Form



ONLY the prescriber may complete this form.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information, please visit the PrimeWest Health System web site at www.primewest.org.

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	Patient's telephone #:	DOB (mm/dd/yy):
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INSURANCE INFORMATION

Member's Insurance ID Number:	Member's Insurance Group Number:
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PHYSICIAN/CLINIC INFORMATION

Prescriber Name:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PRIOR AUTHORIZATION INFORMATION

Patient's Diagnosis:
Medication Requested:
<p>1. What is the patient's bone mineral density (BMD) T-score? _____</p> <p>2. Does the patient have a history of fragility-related fracture? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Is the patient currently treated with Forteo? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with Forteo started? _____</p> <p>4. Does the patient have a history of past use of a bisphosphonate (e.g. Fosamax, Actonel, Boniva) or a selective estrogen receptor modulator (SERM) such as Evista? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, does the patient have contraindications to bisphosphonates or SERMS? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Is the patient currently treated with a bisphosphonate or SERM? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, will the bisphosphonate or SERM be discontinued? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Please include any additional information that should be considered with this review _____</p> <p>_____</p> <p>_____</p>

Please fax or mail this form to:
 PrimeWest Health System
 Clinical Review Department
 1020 Discovery Road, No. 100
 Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 **Phone:** 800.711.9866

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