*Texas Standard Prior Authorization Form Addendum*

# Molina Healthcare of Texas
## Forteo (Teriparatide) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Forteo (Medicaid).

| Drug Name (select from list of drugs shown / provide drug information) |
|---|
| FORTEO 600MCG/2.4ML PEN INJ |

| Patient Information | |
|---|---|
| Patient Name: | |
| Patient ID: | |
| Patient DOB: | |

| Prescribing Physician | |
|---|---|
| Physician Name: | |
| Physician Phone: | |
| Physician Fax: | |
| Physician Address: | |
| City, State, Zip: | |

| | |
|---|---|
| Diagnosis: | ICD Code: |
| Directions for administration: | |

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   *If the answer to this question is yes, approved for 365 days.*
   *If the answer to this question is no, go to question 2.*

2. Is the patient less than 18 years of age or have an open epiphyses? Y N
   *If the answer to this question is yes, denied.*
   *If the answer to this question is no, go to question 3.*

3. Does the patient have a diagnosis of Paget's disease or primary hyperparathyroidism in the last 365 days? Y N
   *If the answer to this question is yes, denied.*
   *If the answer to this question is no, go to question 4.*

4. Does the patient have a diagnosis of osteoporosis in the last 730 days? Y N
   *If the answer to this question is yes, go to question 5.*
   *If the answer to this question is no, denied.*

5. Has the patient had one claim for teriparatide in the last 90 days? Y N

*If the answer to this question is yes, go to question 6.*
*If the answer to this question is no, go to question 7.*

6. Has the patient had greater than or equal to 730 days of therapy in the last 5 years? Y N
*If the answer to this question is yes, denied.*
*If the answer to this question is no, go to question 8.*

7. Has the patient had one claim for another medication included in Table A (below) for osteoporosis in the last 180 days? Y N
*If the answer to this question is yes, go to question 8.*
*If the answer to this question is no, denied.*

8. Is this request for a non-preferred drug? Y N
*If the answer to this question is yes, go to question 9.*
*If the answer to this question is no, approved for 365 days.*

9. Has the patient failed a 30-day treatment trial with at least 1 preferred agent within the last 180 days? Y N
*If the answer to this question is yes, approved for 365 days.*
*If the answer to this question is no, go to question 10.*

10. Is there a documented allergy or contraindication to preferred agents in this class? Y N
*If the answer to this question is yes, approved for 365 days.*
*If the answer to this question is no, go to question 11.*

11. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
*If the answer to this question is yes, approved for 365 days.*
*If the answer to this question is no, denied.*

| **Table A** |
|---|
| **Required quantity:** 1<br>**Look back timeframe:** 180 days |
| ACTONEL |
| ALENDRONATE |
| ATELVIA DR |
| BINOSTO |
| BONIVA |
| CALCITONIN-SALMON SPRAY |
| ETIDRONATE |
| EVISTA |
| FORTICAL NASAL SPRAY |
| FOSAMAX |
| FOSAMAX PLUS D |
| IBANDRONATE |
| MIACALCIN NASAL SPRAY |
| PROLIA |
| RALOXIFENE |
| RISEDRONATE |

Comments:

*I affirm that the information given on this form is true and accurate as of this date.*

| | |
|---|---|
| _____ | _____ |
| Prescriber (or Authorized) Signature | Date |