



**TERIPARATIDE (Forteo®)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

| PRESCRIBER INFORMATION | | PATIENT INFORMATION |
|------------------------------|---|-------------------------|
| PHYSICIAN NAME | PROVIDER ID/TAX ID (if out of state must have tax ID) | PATIENT NAME |
| CONTACT PERSON/PRACTICE NAME | | PATIENT'S BCBSNC ID |
| PRACTICE PHONE | PRACTICE FAX | PATIENT'S DATE OF BIRTH |
| PRACTICE ADDRESS | CITY | STATE ZIP |

Dx code: _____

- Is the patient 18 years or older? Yes No
- Has the patient failed or is unable to tolerate at least ONE oral bisphosphonate or has contraindications to receiving treatment with an oral bisphosphonate? Yes No
- Will the patient receive concurrent treatment with a bisphosphonate? Yes No
- Does the patient have any of the following conditions where the use of teriparatide would not be recommended? (Hypercalcemia, Paget's disease, prior radiation therapy involving the skeleton, bone metastases or history of skeletal malignancies, metabolic bone disease other than osteoporosis) ... Yes No
- a. Has the patient used, or is currently using, teriparatide (Forteo)? Yes No
 b. If Yes, how many months' therapy with Forteo has the patient completed? _____ months

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

**For BCBSNC members, fax form to 1-800-795-9403
For NC State Health Plan members (Member ID starts with YPY),
fax form to 1-866-225-5258**