Fax Referral To: 800-323-2445
Phone: 866-278-6634

Forteo® (teriparatide)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: ________ **Needs by Date (Please Specify):** __________

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** ____________________

PATIENT INFORMATION

(Complete the following or ***send patient demographic sheet****)*

Patient Name: ____________________
Address: ____________________
City, State, Zip: ____________________
Home Phone: ____________________
Alternate Phone: ____________________
SS #: ____________________
Insurance ID: ____________________
Date of Birth: __________ Gender: __________

PRESCRIBER INFORMATION

Prescriber's Name: ____________________
State License #: __________ UPIN: __________
DEA #: __________ NPI #: __________
Group or Hospital: ____________________
Address: ____________________
City, State Zip: ____________________
Phone: __________ Fax: __________
Contact Person: ____________________
Contact Phone: ____________________

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: __________ Subscriber ID#: __________ Name of Insurer: **Blue Cross Blue Shield of RI**
Secondary Insurance: Subscriber: __________ Subscriber ID#: __________ Name of Insurer: __________

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ 733.0 Osteoporosis ☐ Other: __________ • Date of Diagnosis: __________

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

- What is patient's bone mineral density (BMD)? Specify T-Score: __________
- Patient has sustained a fragility fracture or compression fracture due to osteoporosis despite treatment with antiresorptive therapy ☐ Yes ☐ No
  Please specify site of fragility or compression fracture: __________
- Patient is intolerant or has a contraindication to other osteoporosis therapy, including biphosphonates ☐ Yes ☐ No
  Please document the contraindication or intolerance: ____________________
- How many months (lifetime) has the patient received therapy with Forteo? ________ months
- Patient has a diagnosis of esophageal stricture, achalasia, or other severe esophageal dysmotility disorder ☐ Yes ☐ No
- Patient has a history of severe malabsorption making use of oral bisphosphonates ineffective ☐ Yes ☐ No
- Patient has an inability to stand or sit upright for 60 minutes ☐ Yes ☐ No
- Patient has tried and is intolerant to 2 or more oral bisphosphonates ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Forteo® (teriparatide)	750ug/3ml Pen	Inject 20ug (0.08ml) SC QD as directed	☐ 1 Pen *(4-week supply)* ☐ 3 pens *(12-week supply)*	______ ______
☐ PEN NEEDLES 31 gauge ☐5mm ☐6mm ☐8mm		Use with Forteo® Pen as directed	☐ 4-week supply ☐ 12-week supply	______ ______

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

IMPORTANT NOTICE: *This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Forteo PAB 122209*