Forteo and Prolia Prior Authorization Form

Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (866) 440-9345
Phone: (833) 325-0105

Date(MM/DD/YYYY):_____

Patient Information

Name: _____ DOB(MM/DD/YYYY): _____

Medicaid Assistance Number: _____ ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Contact Person for this Request:

Name: _____ Phone: _____ Fax: _____

Diagnosis: _____

❑ The diagnosis mentioned above is an FDA-approved indication for the prescribed medication

❑ All FDA precautions/warnings and contraindications to treatment have been considered.

❑ Receiving at a minimum both calcium 1000 mg and vitamin D 400 IU daily.

❑ **Forteo only: Duration of treatment will be/is no longer than 2 years during a patient's lifetime.**

❑ **Prolia only: PA request beyond six (6) doses will be handled case by case upon reviewing the submitted documentation that the benefit outweighs the risk.**

Directions for use: _____

I attest that

❑ Patient has experienced treatment failure or intolerance to bisphosphonates.

❑ Lab test results and clinical data will be evaluated and monitored.

❑ The requested medication is not part of a clinical trial.

❑ The benefits of the treatment outweigh the risks and the information provided on this form is true and accurate to the best of my knowledge.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original signature.

Prescriber's Signature_____ Date_____