

Drug Coverage Review Request

Forteo



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

PRESCRIBER

MD First Name _____
MD Last Name _____
Address _____
City _____
State _____
Zip Code _____
Phone _____
Fax _____
DEA number (optional) _____

PATIENT

Cardholder ID # _____
Patient Last Name _____
Patient First Name _____
Date of Birth _____
Address _____
City _____
State _____
Zip Code _____
Phone _____

Medco manages the prescription drug benefit for your patient on behalf of his/her plan sponsor. Your patient's prescription drug benefit has a preferred drug list to help keep benefits affordable, and certain medications require a review for determination of coverage. The medication that you have prescribed requires a coverage review. To request consideration for coverage of the non-preferred medication, please complete the following questions and then fax this form to the toll-free number shown below. Upon receipt of the completed form, prescription benefit coverage for the non-preferred medication will be decided.

SECTION A Please answer the following questions

- Yes* No Is the patient currently receiving this medication?
**IF YES to the previous question, the safety and efficacy of this drug has not been evaluated beyond 2 years of treatment. Consequently, use of the drug for more than 2 years is not recommended.*
- Yes No Has the patient received this medication for more than 2 years?
- Yes No Is this medication being prescribed for the treatment of osteoporosis?
- Yes No Will the patient be receiving both this medication AND a bisphosphonate?
- Yes No Has previous drug therapy with a bisphosphonate failed to treat this patient's osteoporosis?
- Yes No IF NO to the previous question, is this patient able to receive drug therapy with a bisphosphonate?
- Yes No Does this patient have any of the following conditions where use of this medication would **NOT** be recommended: hypercalcemia, Paget's disease, prior radiation therapy involving the skeleton, bone metastases, history of skeletal malignancies, or metabolic bone disease other than osteoporosis?

SECTION B Physician Signature

PHYSICIAN SIGNATURE

DATE

FAX COMPLETED FORM TO: 1 800 837-0959

PLEASE DO NOT FAX WITH A COVER SHEET



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