

Request Form for Teriparatide INJ [Forteo®]

Physician Information

Name: _____
License: _____ Physician specialty: _____
Address: _____
Telephone: _____ Fax: _____

Patient Information

General Information

Name: _____	Member ID: _____
Date of birth: _____	Address: _____
Sex: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____	_____

Medication requested:

Name: Forteo (teriparatide) Dose: 20 mcg subcutaneous once daily

Medical Information

Please answer the following questions:

1) The patient presents the following diagnosis: Please select

- Post menopausal women with diagnosis of osteoporosis with T score ≤ -2.5 (T-2.5) and high risk for fracture, with any of the following:
- Men with primary or hypogonadal osteoporosis with T score ≤ -2.5 (T-2.5) and high risk for fracture, with any of the following:
- Men and women with osteoporosis associated with sustained systemic glucocorticoid therapy

2) Does the patient have history of osteoporotic fracture? yes no

3) Does the patient have multiple risk factors for fracture ? yes no

If yes, please select:

- | | |
|---|--|
| <ul style="list-style-type: none"><input type="checkbox"/> Femoral neck BMD<input type="checkbox"/> Rheumatoid arthritis<input type="checkbox"/> Alcohol intake (more than 3 drinks/d)<input type="checkbox"/> Current smoking<input type="checkbox"/> Parental history of hip fracture | <ul style="list-style-type: none"><input type="checkbox"/> Body mass index (kg/m²)<input type="checkbox"/> Secondary osteoporosis<input type="checkbox"/> Oral glucocorticoid ≥ 5mg of prednisone or equivalent use for more than 3 months ever |
|---|--|

4) Failure to previous osteoporosis therapy? yes no

5) Intolerance to previous osteoporosis therapy? yes no

Please provide any medical information which may support approval: (optional)

Physician signature: _____

Date: _____