Forteo Coverage Determination

HEALTHSPRING
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bravo HEALTH
a HEALTHSPRING company

For HealthSpring Coverage Determinations please fax requests to: 866-845-7267
For Bravo Health Coverage Determinations please fax requests to: 866-464-0709

Office Contact:	**Provider Specialty:**
Provider First Name:	**Provider Last Name:**
Provider Phone:	**Provider Fax:**

Provider Address:

License Number:	**DEA Number:**	**NPI Number:**

Member Name:

Member Address:

Member Phone:(H)	**(C)**
Member ID:	**DOB:**

Rx		**Prescription Information**		
Drug:		**Dosage:**	**Frequency:**	**Quantity:**
□ **Brand**	□ **Generic**	□ **New Medication**	□ **Continuation (Provide Start Date)**	**Refills:**

Select Diagnosis:

Postmenopausal Female with Osteoporosis _____ Other: _____

Primary or Hypogonadal Osteoporosis _____ _____

Glucocorticoid-induced Osteoporosis _____

Has the member had a previous osteoporotic fracture while receiving bisphosphonate therapy? Yes No

If yes, please provide the date of the fracture: _____

List the duration of bisphosphonate therapy: _____

List T-Score: _____

Does the member have a medical condition that caused in bone loss significantly greater than the patient's age? Yes No

List the medical condition: _____

Has the member developed irritation of the upper GI mucosa evidenced by dysphagia, odynophyagia, or retrosternal pain? Yes No

Administration Site: Patient's home: _____ Home infusion: _____ Skilled nursing: _____
Physician's office: _____ Long Term Care: _____ Other: _____

Drug Supplied By: **Pharmacy:** ☐ **Physician's supply:** ☐ **Other:** _____

Additional information must be submitted to support medical necessity.

History of bisphosphonates used to treat the above condition				
Medication Trial/ Previous Therapies	**Date of Therapy Start & End Dates**	**Strength**	**Frequency**	**List adverse reactions/side effects/reason for stopping**

☐ ***Request for expedited review[24 hours]. By checking this box, I certify that applying the 72 hour standard review time frame may seriously jeopardize the life or health of the member or the member's ability to regain maximum function***

Provider Signature: **Date:**

*For specialty medications, I authorize HealthSpring as my designated agent to forward the above prescription to the preferred specialty pharmacy