Jefferson Health Plans

***PRIOR AUTHORIZATION REQUEST FORM***
Individual and Family Plans

# Teriparatide

**Fax back to: (833) 605-4407**
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

**PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.**

| **Patient Name:** | **Prescriber Name:** |
|---|---|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Exchange - PA | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | **Specialty/facility name (if applicable):** |

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

| | |
|---|---|
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |

**Please attach any pertinent medical history including labs and information for this member that may support approval.**
**Please answer the following questions and sign.**

Q1. Is this a renewal request?

☐ Yes - Go to 2 ☐ No - Go to 4

Q2. For RENEWALS: Does the patient's lifetime cumulative therapy not exceed 2 years?

☐ Yes ☐ No

Q3. For RENEWALS: Does the patient remain at or has returned to having a high risk for fracture despite a total of 24 months of use of parathyroid hormones?

☐ Yes ☐ No

Q4. Does the patient have a documented diagnosis of osteoporosis (glucocorticoid-induced, primary or hypogonadal in men, or postmenopausal in women)? Please submit documentation.

☐ Yes ☐ No

Q5. Is the patient 18 years of age or older?

☐ Yes ☐ No

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Q6. Are the following baseline labs (T-score) attached?

☐ Yes ☐ No

Q7. Has the patient had an inadequate response or the inability to tolerate at least one of the following: bisphosphonates, hormone replacement therapy, selective-estrogen receptor modulators (SERMs) or Denosumab (Prolia)?

☐ Yes ☐ No

Q8. Is the request for a formulary product?

☐ Yes ☐ No

Q9. Is there documentation of an inadequate response, intolerance, or contraindication to all formulary products indicated for the diagnosis that would not be expected to occur with requested agent?

☐ Yes ☐ No

Q10. Additional Information:

Prescriber Signature

Date

*v2026*

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