Prescriber Criteria Form Teriparatide 2026 PA Fax 94-A v1 010126.docx Bonsity, Forteo (teriparatide), teriparatide Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**. Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Teriparatide.

Drug Name (select from list of drugs shown):

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have postmenopausal osteoporosis? [If no, then skip to question 7.]	Yes	No
2	Has the patient previously received greater than or equal to 24 months of therapy with the requested drug or any parathyroid hormone analog? [If yes, then skip to question 21.]	Yes	No
3	Does the patient have a history of fragility fractures? [If yes, then no further questions.]	Yes	No
4	Does the patient have pre-treatment T-score of less than or equal to -2.5? [If yes, then skip to question 6.]	Yes	No
5	Does the patient have a pre-treatment T-score greater than -2.5 and less than -1 and EITHER of the following: A) a 10-year Fracture Risk Assessment Tool (FRAX) fracture probability of greater than or equal to 20 percent for any major osteoporotic fracture, B) a 10-year FRAX fracture probability of greater than or equal to 3 percent for hip fracture? Note: If glucocorticoid treatment is greater than 7.5 milligrams (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture. [If no, then no further questions.]	Yes	No
6	Does the patient have ANY of the following: A) Indicators for higher fracture risk (e.g., advanced age, frailty, glucocorticoid therapy, very low T-scores, or increased fall risk), B)	Yes	No

	Patient has failed prior treatment with or is intolerant to a previous injectable osteoporosis therapy, C) Patient has had an oral bisphosphonate trial of at least 1-year duration or there is a clinical reason to avoid treatment with an oral bisphosphonate? [No further questions.]		
7	Is the requested drug for primary or hypogonadal osteoporosis in men? [If no, then skip to question 14.]	Yes	No
8	Has the patient previously received greater than or equal to 24 months of therapy with the requested drug or any parathyroid hormone analog? [If yes, then skip to question 21.]	Yes	No
9	Does the patient have a history of an osteoporotic vertebral or hip fracture? [If yes, then no further questions.]	Yes	No
10	Does the patient have a pre-treatment T-score of less than or equal to -2.5? [If yes, then skip to question 12.]	Yes	No
11	Does the patient have a pre-treatment T-score greater than -2.5 and less than -1 and EITHER of the following: A) A 10-year Fracture Risk Assessment Tool (FRAX) fracture probability of greater than or equal to 20 percent for any major osteoporotic fracture, B) A 10-year FRAX fracture probability of greater than or equal to 3 percent for hip fracture? Note: If glucocorticoid treatment is greater than 7.5 milligrams (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture. [If no, then no further questions.]	Yes	No
12	Has the patient failed prior treatment with, or is the patient intolerant to, a previous injectable osteoporosis therapy? [If yes, then no further questions.]	Yes	No
13	Does the patient meet either of the following: A) the patient has had an oral bisphosphonate trial of at least 1-year duration, B) there is a clinical reason to avoid treatment with an oral bisphosphonate? [No further questions.]	Yes	No
14	Does the patient have a diagnosis of glucocorticoid-induced osteoporosis? [If no, then no further questions.]	Yes	No
15	Has the patient previously received greater than or equal to 24 months of therapy with the requested drug or any parathyroid hormone analog? [If yes, then skip to question 21.]	Yes	No
16	Has the patient had an oral bisphosphonate trial of at least 1-year duration? [If yes, then skip to question 18.]	Yes	No
17	Has the patient experienced an intolerance or has a contraindication to an oral bisphosphonate? [If no, then no further questions.]	Yes	No

18	Does the patient have a history of fragility fracture? [If yes, then no further questions.]	Yes	No
19	Does the patient have a pre-treatment T-score of less than or equal to -2.5? [If yes, then no further questions.]	Yes	No
20	Does the patient have a pre-treatment T-score greater than -2.5 and less than -1 and EITHER of the following: A) a 10-year Fracture Risk Assessment Tool (FRAX) fracture probability of greater than or equal to 20 percent for any major osteoporotic fracture, B) a 10-year FRAX fracture probability of greater than or equal to 3 percent for hip fracture? Note: If glucocorticoid treatment is greater than 7.5 milligrams (prednisone equivalent) per day, the estimated risk score generated with FRAX should be multiplied by 1.15 for major osteoporotic fracture and 1.2 for hip fracture. [No further questions.]	Yes	No
21	Does the patient remain at or has returned to having a high risk for fracture? [If no, then no further questions.]	Yes	No
22	Does the benefit of therapy with this prescribed medication outweigh the potential risks for this patient?	Yes	No

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: _____ **Date:**_____