

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For all requests continued:

6. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? Yes No
7. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required.** Yes No
8. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? . Yes No
9. Has the patient tried and had an inadequate response to a bisphosphonate? **Please note, medical records are required.** Yes No
 If no, does the patient have an intolerance or hypersensitivity to a bisphosphonate? **Please note, medical records are required.** Yes No
 If no, does the patient have an FDA labeled contraindication to ALL bisphosphonates? **Please note, medical records are required.** Yes No
10. Was the patient's diagnosis confirmed by ONE of the following: 1) a fragility fracture in the hip or spine, 2) a T-score of -2.5 or lower, or 3) a T-score of -1.0 to -2.5 and fragility fracture of the proximal humerus, pelvis, or distal forearm, a FRAX 10-year probability for major osteoporotic fracture of greater than or equal to 20%, or 4) a T-score of -1.0 to -2.5 and a FRAX 10-year probability of hip fracture of greater than or equal to 3%?..... Yes No
11. Is the patient at a very high fracture risk as defined by ONE of the following: 1) patient had a recent fracture (within the past 12 months), 2) patient had fractures while on FDA approved osteoporosis therapy, 3) patient has had multiple fractures, 4) patient had fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids), 5) patient has a very low T-score (less than -3.0), 6) patient is at high risk for falls or has a history of injurious falls, or 7) patient has a very high fracture probability by FRAX (e.g., major osteoporosis fracture greater than 30%, hip fracture greater than 4.5% or by other validated fracture risk algorithm? Yes No

For glucocorticoid-induced osteoporosis requests:

12. Is the patient either initiating or currently taking glucocorticoids in a daily dosage equivalent to 5 mg or higher of prednisone? Yes No
13. Is the patient's expected current course of therapy of glucocorticoids for a period of at least 3 months?..... Yes No
14. If the patient is less than 40 years of age, does the patient have ONE of the following: 1) a prior fracture, 2) either initiating or currently taking glucocorticoids that are equivalent to a prednisone dose that is greater than or equal to 30 mg/day, or 3) either initiating or currently taking glucocorticoids that are equivalent to a cumulative prednisone dose of greater than or equal to 5 g/year? Yes No
15. If the patient is 40 years of age or older, does the patient have ONE of the following: 1) a prior osteoporotic fracture, 2) a T-score of less than or equal to -2.5, 3) a FRAX 10-year probability for major osteoporotic fracture of greater than or equal to 20%, 4) a FRAX 10-year risk probability for hip fracture of greater than or equal to 3%, 5) either initiating or currently taking glucocorticoids that are equivalent to a prednisone dose that is greater than or equal to 30 mg/day for greater than 30 days, or 6) either initiating or currently taking glucocorticoids that are equivalent to a cumulative prednisone dose of greater than or equal to 5 g/year? Yes No

For osteoporosis requests:

16. Does the patient have a diagnosis of osteoporosis? Yes No
17. If male, is the patient's age 50 years or over? Yes No
 If no, please provide support that the requested agent is medically appropriate for the patient's age and sex: _____
18. If female, is the patient postmenopausal? Yes No
 If no, please provide support that the requested agent is medically appropriate for the patient's sex and menopause status: _____

For Bonsity, Forteo (brand), or Teriparatide requests:

19. Has the patient tried and had an inadequate response to Forteo generic equivalent?..... Yes No
20. Was Forteo generic equivalent was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? **Please note, chart notes are required.**..... Yes No

Please continue to the next page.

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<p>21. Does the patient have an intolerance or hypersensitivity to Forteo generic equivalent that is not expected to occur with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain intolerance/hypersensitivity: _____</p>			
<p>22. Does the patient have an FDA labeled contraindication to the generic equivalent that is not expected to occur with the brand agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify FDA labeled contraindication: _____</p>			
<p>23. Is Forteo generic equivalent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Please note, chart notes are required..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>24. Is Forteo generic equivalent not in the best interest of the patient based on medical necessity? Please note, chart notes are required..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>25. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as Forteo generic equivalent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Please note, chart notes are required..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<p>26. Is there support for the use of the requested brand agent over the Forteo generic equivalent? Please provide supporting information..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121 TOLL FREE		CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.	
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