



FORTEO
 REIMBURSEMENT SUPPORT FORM
RX Biotech Specialty Pharmacy
 8737 Beverly Blvd. Los Angeles, CA 90048
 Phone (800) 657-2212
 FAX (310)657-0906

Pharmacy will do all prior authorizations for insurances and delivers Forteo to the patients.
Please FAX this form along with COPY OF INSURANCE CARD.

__ FORTEO 600mcg/2.4ml Pen, sig: 20 mcg SQ daily for 2 years
 __ Pen Needles 31 Gauge 5 mm- 1 box of 100 needles – Use 1 needle daily with FORTEO Pen

PATIENT INFORMATION:

Patient Name: _____
 Patient Address: _____
 City, State, Zip: _____
 Date of Birth: _____
 Patient Phone #: _____
 SS#/ ID#: _____

PHYSICIAN INFORMATION:

Physician Name: _____
 Address: _____
 City, State, Zip: _____
 Phone #: _____ Fax#: _____
 DEA # _____ NPI#: _____
 State License # _____
 Tax ID # _____

PATIENT MEDICAL HISTORY:

Date of Osteoporosis Diagnosis: _____
 DEXA T- score (worst sites): _____
 Previous Fracture(s): Y or N _____
 Site of Fracture(s): _____
 Other: _____

Prior (Failed) Medications: Duration:

Calcium + VitD _____
Fosamax (alendronate) _____
Actonel (risedronate) _____
Miacalcin Nasal Spray _____
Evista (raloxifene) _____
Boniva _____
Reclast _____
Steroids _____

If known, provide T-score BEFORE and AFTER treatment with above listed medication(s)
 Medication: _____

T-Score at Baseline (with date): _____
 T-Score After (with date): _____

Is patient unable to tolerate bisphosphonates (alendronate or risedronate)? _____

Patient Preferred Language: _____

Physician Signature: _____ Date: _____

By signing this Rx, MD authorizes the pharmacy to contact insurance company as his/her agent for prior authorization purposes.