

Complete Patient and Physician information (PLEASE PRINT)

STEP 1	Member Name:	Physician Name:
	Address:	Address:
	Member ID:	Phone #:
	Member DOB:	Fax #:

If Applicable: Pharmacy Name: _____
 Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP 2	Diagnosis	<input type="checkbox"/> Osteoporosis documented by bone densitometry (e.g. DXA) <input type="checkbox"/> High risk of fracture (history of fracture due to osteoporosis or multiple risk factors for fracture)	<input type="checkbox"/> Other (please state):
	Clinical Information	<input type="checkbox"/> Patient failed and/or is intolerant to previous osteoporosis therapy (Fosamax, Evista, Didronel, Myacalcin, Aredia) Failed previous therapy with which medication(s): _____	
	Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (required): Please attach a copy of the prescription or provide ALL of the information below: Forteo [®] (teriparatide) Strength _____ Sig _____ Qty _____ Refills _____ Please attach all relevant medical records and test results. <p style="text-align: center;">Incomplete forms will not be processed.</p>	

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

STEP 3	_____	_____
	Prescriber Signature	Date

**STEP 4 Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
 970-248-5034**

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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